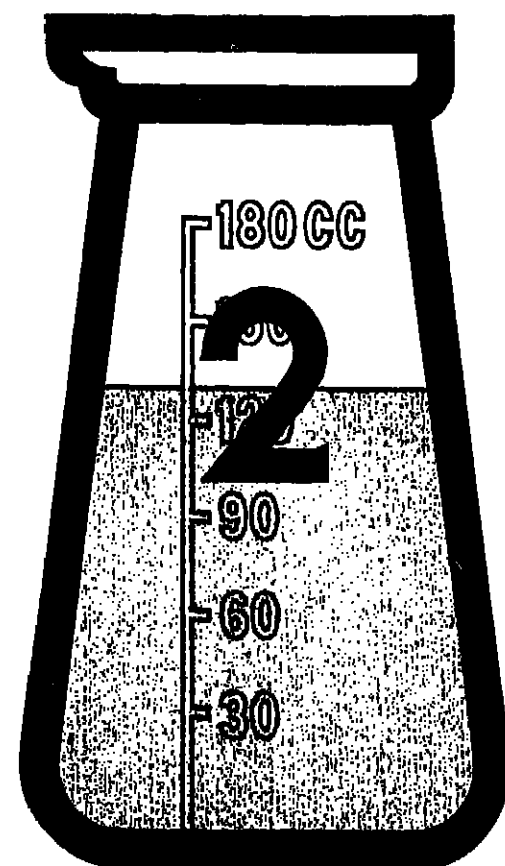


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Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical

signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

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Adverse Reactions: Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); allergic reactions (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); gastrointestinal reactions (nausea, emesis, abdominal pain, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); CNS reactions (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucina-

tions, tinnitus, vertigo and insomnia); miscellaneous reactions (drug fever, chills, toxic nephrosis with oliguria and anuria, periarthritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some gottogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of galacturonic aciduria, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

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Med Trib 17

Medical Tribune

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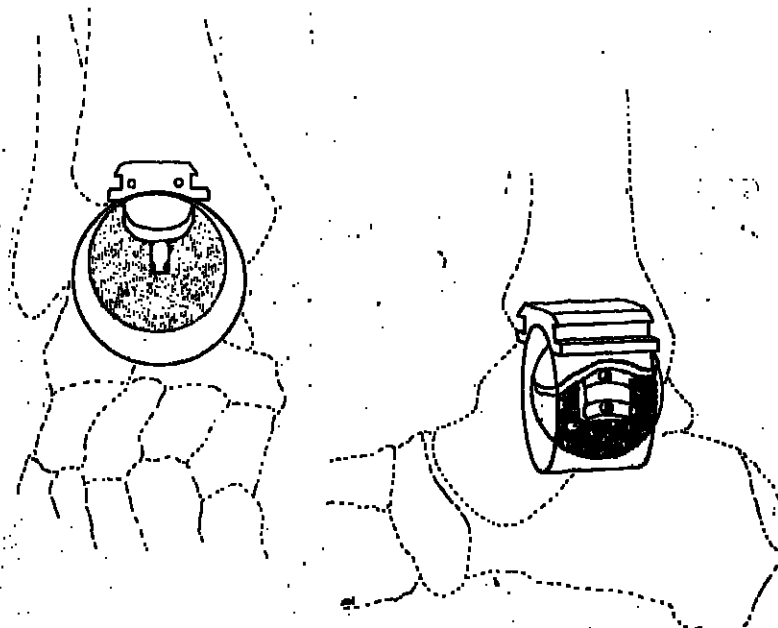
Vol. 16, No. 17

world news of medicine and its practice—fast, accurate, complete

and Medical News

Wednesday, May 7, 1975

New Polyethylene-Vitalium Prosthesis



Ankle joint prosthesis developed by Dr. St. Elmo Newton has tibial unit made of cylindrical section of polyethylene and talar unit made of spherical section of Vitalium with slightly smaller radius. Arthroplasty has shown encouraging results so far in arthritic patients who would have been candidates for ankle fusion.

Artificial Ankle Seen Better Than Fusion in Some Cases

Medical Tribune Report

SAN FRANCISCO—Total ankle arthroplasty may be preferable to fusion in patients with degenerative and rheumatoid arthritis and avascular necrosis of the talus. Dr. St. Elmo Newton of the Seattle Orthopaedic and Fracture Clinic told a meeting of the American Academy of Orthopaedic Surgeons here.

Dr. Newton used a prosthesis of high density polyethylene and Vitalium to replace the ankle joint in 30 patients suffering from severe pain and immobility, who would all have been considered candidates for ankle fusion. He noted that fusion operations have been reported to result in a significant incidence of non-union, infection, loss of position, and need for repeated surgery.

Preliminary data on the patients undergoing total arthroplasty over the past two years are "very encouraging," Dr. Newton said, both in terms of relief from pain and preservation of motion.

Continued on page 2

Mayo Investigator Stresses Rauwolfia Study's Limitation

Medical Tribune Report

NEW YORK—In a MEDICAL TRIBUNE followup telephone interview, Dr. W. M. O'Fallon of the Mayo Clinic clarified and amplified earlier reports of the study which he and his colleagues conducted to ascertain whether rauwolfia derivatives such as reserpine were associated with breast cancer. Their study did not support such a relationship and was reported at the American Heart Association Council on Epidemiology meeting in Tampa (MT, April 9).

Shock Correction of Heart Rhythm Delayed in 3% Up to 103 Seconds

By HARRIET PAGE
Medical Tribune Staff

SAN FRANCISCO—Conversion to normal sinus rhythm after DC shock for converting supraventricular arrhythmias may occur after a delay of up to two minutes, the 56th annual meeting of the American College of Physicians was told here. Drs. Wolf F. C. Duvernoy and Daniel T. Anbe, of the Division of Cardiovascular Disease at Henry Ford Hospital in Detroit, said they encountered six such cases out of a total of 203 consecutive patients.

While the exact mechanism of the delayed conversion is unclear, Dr. Duvernoy said, "we conclude that a repeat shock should not be administered immediately after apparent failure to establish normal sinus rhythm with direct current shock."

The six patients they saw with delayed conversion, Dr. Duvernoy said, took from four to 103 seconds after DC shock to convert to normal sinus rhythm. Their ages ranged from 36 to 63 and all were men.

Four had paroxysmal atrial flutter, two had atrial fibrillation, three had no demonstrable underlying organic heart disease, one had questionable alcoholic cardiomyopathy, and for one no diagnosis was available. Three patients received a shock of 50 watt-seconds and three of 100 watt-seconds. The immediate postshock rhythm was atrial fibrillation in all six patients, which then

Continued on page 12

Nationwide Use Effective

Rubella Vaccine Breaks 6-9-Year Epidemic Cycle

By FRANCES GOODNIGHT
Medical Tribune Staff

NEW YORK—This country's cycle of rubella epidemics now seems to have been broken by nationwide use of rubella vaccine, Dr. Louis Z. Cooper, of the Columbia University College of Physicians and Surgeons, said here.

Dr. Cooper, a key figure in congenital rubella research, said the nonappearance of an epidemic expected during the early 1970s marked the first disruption of the disease's usual six-to-nine-year epidemic cycles since compilation of rubella statistics began in this city 45 years ago.

National records have been kept for a much shorter period but the investigator believes the New York City records parallel those of the United States as a whole. He noted that the last epidemic, striking in 1964, resulted in the birth of at least 20,000 severely affected infants.

Dr. Cooper warned, however, that vaccination programs are still failing to reach many children.

Current figures indicate that only 60 per cent of children aged one to four and 80 per cent of those between the ages of five and nine are immunized. Dr. Cooper told a symposium on infections of the fetus and newborn held

Continued on page 18

**making
rounds** at press time

DEFINITION OF DEATH may be changed in New York to include cessation of brain function. Proposed law being considered by Health Committee of state legislature and supported by N.Y. County medical society and Manhattan district attorney would give surgeons right

to remove organs for transplant when brain activity ceases. Present common law requires cessation of heart-beat, is said by reformers to be outmoded. Four states have passed brain death statutes so far, fourteen are studying similar measures.

INDIANA MALPRACTICE bill (MT April 23) is now law following signature by Gov. Otis R. Bowen, himself an MD. "We think we have the best, most comprehensive

bill in any state," Dr. Bowen said. "Of course you have to see it in operation before you really know what you have." Dr. Paul F. Miller, co-chairman of state medical association committee for the bill, added, "We already have a commission to study reports from insurance companies in depth for the next year and a half, so that any changes we need can be made promptly."

LIMB MUSCLE TRANSPLANT — U. of Michigan team reports

successful free transplants in cats of muscle from one limb to same site on opposite leg, with restoration of up to 50% of normal nontransplanted mass and 30% of muscle's contractile tension. Success depends on denervation of muscle about 3 weeks before transplantation, investigators say. Muscles not denervated until time of transplant regenerated far more slowly (if at all) and regained much less functional ability.

Same Catheter Used for Angiography, Embolization



Blood flow to kidney tumor can be reduced or halted by inserting gelatin sponge at a point in artery feeding the tumor. Embolization is performed following angiography to outline vessel pattern, and is done through same catheter used for the angiography. At left, angiogram of kidney. At right, blood supply is cut off following placement of the artificial embolus. Embolization can be performed prior to resection of the tumor to reduce tumor vascularity, according to Dr. Wallace, or to reduce tumor size, or as a palliative measure to reduce pain and hematuria.

New Techniques Pave Way For 'Intervention Radiology'

By MICHAEL HERRING
Medical Tribune Staff

NEW YORK—With new radiologic techniques and instrumentation for detecting, localizing, and treating cancer and other diseases, the radiologist has changed his image from "the person behind the red goggles to an activist in patient management," Dr. Sidney Wallace told a forum of the American College of Radiology here.

In an interview with MEDICAL TRIBUNE, Dr. Wallace, who is Professor of Radiology at University of Texas System Cancer Center, and M. D. Anderson Hospital and Tumor Institute, Houston, described the emerging field of "intervention radiology."

Stopping Internal Bleeding

With the image intensifier, the radiologist now has the ability to stop bleeding from tumors and other internal bleeding sites by various catheter procedures, without opening up the body, he said. "After identifying bleeding vessels with angiography, we can use the catheter to inject vasopressin, angiotensin, and other agents that constrict vessels. This we do to stop bleeding after surgical removal of polyps, for example."

"Bleeding stomach lymphomas have been similarly occluded using the patient's own body tissue. Emboli and gel-foam are very good preoperative measures for vascular tumors such as those of the kidney," he added. "By occluding these before surgery, we present the surgeon with a relatively bloodless field, which saves operating time, prevents blood loss, and defines the tumor better."

Dr. Wallace also described catheter insertion of a plug to stop the shunt of blood in patent ductus arteriosus without surgery. "In France, meningiomas and other spinal malformations have also been occluded by the radiologist prior to surgery," he said. "And in

Russia, the catheter has been used to inflate a small balloon within the fistula between the carotid artery and cavernous sinus caused by trauma to the head."

Radiologists are also involved in dilation and removal of obstructions, Dr. Wallace added. "Dilating catheters are being used for opening occluded arteries by stretching the lumen of the vessel," he noted.

"In nonthrombotic mesenteric ischemia caused by shock or digitalis toxicity from heart failure treatment, the catheter can drip dilating drugs directly into the spastic vessels that are compromising the bowel."

The radiologist can also remove gallstones still remaining in the biliary ducts after gallbladder surgery, Dr. Wallace said. "These are either crushed with a special catheter or pushed into the duodenum," he explained.

"Formerly the province of the surgeon, bone and lung biopsies are another new area for the radiologist, who can now see where he is going without cutting. We use the same procedures for obtaining a bronchial brushing for cytologic examination, except that the catheter is equipped with a small brush for obtaining the specimen."

Radiologically-guided retroperitoneal lymph node biopsies may be possible in the near future, he stated. "We have already tried this on cadavers and are now working on a means to control the biopsy instrument better, to avoid rupturing nearby blood vessels."

Apartheid Reported Affecting All Phases of Health Services

Medical Tribune World Service

GENEVA—Racial discrimination affects virtually every aspect of South Africa's health services, according to a World Health Organization report on the health implications of apartheid.

The report, prepared by a group of experts for the W.H.O. Executive Board, pointed out, for example, that while the physician-population density for whites, at 1:400, is one of the world's highest, the ratio for Africans, who constitute 70 per cent of the population, is 1:44,400, one of the world's lowest.

Apartheid also applies to salary scales for physicians, with different pay scales according to ethnic origins for doctors with equivalent training and other qualifications, the W.H.O. experts continued. African physicians not only suffer from salary differentials, but are also denied the senior appointments, married quarters, travel allowances, and recreation facilities available to white doctors.

The system of delivering health care "is in flagrant contradiction with the system of ethical values that has prevailed in the medical profession since Hippocratic times," the report commented.

May Not Treat Own Patients

Black doctors are not allowed to treat their own patients in provincial hospitals if this would involve their being placed in a position of authority over white nurses. Ambulances for whites cannot be used to transport non-whites.

A visitor to pediatric units in Johannesburg saw two nurses in the African hospital attempting to feed, change, and care for 37 very ill children, while in a comparable white hospital two nurses were caring for five children who were less ill. He reported that medical services could not cope with the magnitude of disease created by the conditions in which the African and Colored communities were living.

Racial attitudes extend even to the labeling of human blood collected for transfusion, the report said. Under official regulations, the code letters W for whites, K for coloreds, A for Indians or Asiatics, and B for Bantus must be used. No explanation of the purpose of

the labeling is to be found in the regulation, which contains no prohibition on interracial blood transfusion.

Studies showing that there is no serogenetic reason for such labeling have not been challenged by the authorities, but a physician attached to the South Africa Blood Transfusion Service has defended the system on the ground that "in South Africa at the present time all the principal diseases which may be transmitted by transfusion (syphilis, viral hepatitis, and malaria) have higher incidences in nonwhites than in whites." He added that white donors are to be preferred "because of their greater freedom from infectious diseases as a consequence of better socioeconomic and living conditions."

The Medical Association of South Africa has consistently opposed racial discrimination, the report stated. Its federal council has called on the authorities to remove the differential salary structure, and this stand has been backed by editorials in the *South African Medical Journal*. The Medical Association although predominantly white, does not itself practice apartheid, and has officeholders of various ethnic groups.

Artificial Ankle Held Better Than Fusion In Certain Patients

Continued from page 1

The two-part prosthesis fits into the tibia and talus and is bonded to the cancellous bone by methylmethacrylate. The talus is not resected. Dr. Newton said that when the unit is in place it allows polycyclic motion—gliding and rocking as well as rotation, which is a marked advantage over fusion.

Of the patients in whom the prosthesis was inserted, 19 had degenerative arthritis, eight rheumatoid arthritis, two avascular necrosis of the talus, and one pseudoarthrosis of ankle fusion. The average hospital stay was five to seven days, and full weight on the joint was tolerated on the third day.

The average post-op range of motion was five degrees dorsiflexion and 25 degrees plantarflexion. Significant relief from pain was obtained in all but three cases, though "not all have had complete relief," Dr. Newton said.

The three failures in the group involved one fractured distal fibula developing nonunion requiring amputation, one persistent post-op painful valgus, and one infection requiring fusion.

"The prosthetic ankle replacement is recommended at this time only for those patients whose ankle pain is of such severity that fusion would be the only other surgical treatment possible," Dr. Newton said. "It is contraindicated in the face of recent infection, Charcot joint, absent malleolus, or marked ligamentous instability."

Dead Sea Region 'Ideal' For Psoriasis Treatment

Medical Tribune World Service

TEL AVIV—The Dead Sea region offers an ideal location for the natural treatment of psoriasis by the sun's ultraviolet rays, according to Dr. Anthony Domonkos, Clinical Professor of Dermatology at Columbia University College of Physicians and Surgeons.

Dr. Domonkos headed a delegation of 13 dermatologists from the United States who examined new facilities for skin patients established at the Dead Sea.

The region's elevation, 1,300 feet below sea level, provides a unique degree of atmospheric filtration of the sun rays, he noted.

index

CLINICAL NEWS NOTE: "A solid ankle fusion places an additional strain on the knee and tarsal joints on that same side. If problems exist in these joints, as in rheumatoid arthritis, this added strain causes their symptoms to become steadily worse. . . . To relieve pain, yet retain motion in the arthritic ankle, an ankle replacement prosthesis was designed and has been inserted into a small series of patients with very encouraging results." (Dr. St. Elmo Newton, see page 1.)

Medicine: pgs. 1, 2, 3, 5, 6, 12, 18, 19, 20, 22, 23

Aspirin and cold virus shedding: clinicians largely unconcerned . . . 18
Immunosuppressives in ca patients may cause cardiac abnormalities . . . 18
Three drug combination reduces MS relapse rate . . . 23

Surgery: pgs. 1, 7, 12, 13
Helmich maneuver for "cafe coronaries"—basis explained . . . 7
Community hospital demonstrates quality cardiac surgery program . . . 12

Pediatrics: pgs. 1, 5, 7, 13, 18, 23
Rubella vaccine has broken epidemic cycle . . . 1
Family role detected in childhood bronchitis . . . 7

Psychiatry: pgs. 12, 22
Understanding of stress urged for improving mental health of aged . . . 12

feature index

Doctor's Debate . . . 5
Editorial Capsules . . . 6
Editorials . . . 11
Letters to Tribune . . . 5, 11
Cartoons . . . 7, 11, 18, 20, 22
One Man . . . and Medicine . . . 17
Medicine on Stamps . . . 17
Eliot Janevay . . . 20
Cat Clinic . . . 22
Immunaria Medica . . . 23

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In Men 25 to 44, More CHD Found in Blacks

Medical Tribune Report

NEW ORLEANS—Pathologists have been surprised by the discovery in a study here that in men 25 to 44 years of age coronary heart disease is more prevalent among blacks than whites.

Based on 423 autopsies in a 3-year period, the population rate for proven CHD was 74/100,000 for black men and 54/100,000 for white. If less strongly documented CHD cases are added, the statistics become 156/100,000 for blacks and 91/100,000 for whites. The autopsies represent 69 per cent of all deaths in the age group during the three years.

Dr. William A. Rock reported the findings to the International Academy of Pathology meeting here. Dr. Jack P.

Strong, chairman of the department of pathology at the Louisiana State University Medical Center, who also participated in the investigation, said it had been believed earlier that the incidence of CHD was higher among whites.

Part of Community-Wide Study

The necropsies were of 138 white and 285 black men. The work is part of a community-wide comprehensive study of atherosclerosis and coronary heart disease.

Five pathologists used autopsy data and other information to make classifications in four categories. They listed 19 white and 18 black cases as proven CHD, five white and five black as prob-

able CHD, 8 white and 15 black as possible CHD and 106 white and 247 black as without CHD.

Sixty-seven per cent of the CHD cases had large myocardial lesions. Eighteen per cent of questionable CHD (the probable and possible groups) had large lesions. Seven per cent of the non-CHD cases showed such lesions.

Coronary atherosclerosis was demonstrated in 59 per cent of the CHD category, in 31 per cent of the questionable group and in 8 per cent of those without CHD.

Dr. Margaret C. Oelmann works with Drs. Rock and Strong in the New Orleans project, being carried on by L.S.U. and the Veterans Administration Hospital.



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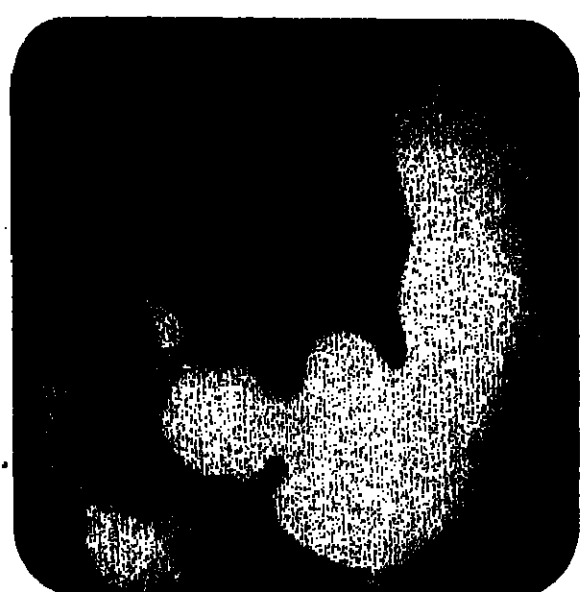
*Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective: For use to relieve pain, in "conditions in which combined sedative and analgesic action is desired, such as, nervous tension and sleeplessness associated with pain or headache." Final classification of the less-than-effective indications requires further investigation.

Contraindications: Hypersensitivity to any of the components. Precautions: Due to presence of a barbiturate, may be habit forming. Excessive or prolonged use should be avoided.

Side Effects: In rare instances, drowsiness, nausea, constipation, dizziness, and skin rash may occur. Adult Dosage: One to two tablets or capsules, repeated if necessary up to 6 per day, or as directed by physician. Before prescribing, see package insert for full product information.

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The Pseudo-ulcer



Ulcer-like symptoms: no G.I. pathology

The patient is convinced it's an ulcer. However, symptoms are not quite typical, and x-ray findings are negative. These findings and the results of additional diagnostic procedures exclude an organic basis for the patient's complaints. A diagnosis of "upper functional gastrointestinal disorder" is made, which is supported by the fact that episodes of painful symptoms coincide with episodes of excessive anxiety, as indicated by the history.

It may be useful to explain to the patient the mechanism by which emotions upset normal G.I. functioning, resulting in hypersecretion and hypermotility and thus causing such symptoms as nausea and epigastric pain. In upper functional gastrointestinal disorders, counseling by the primary physician can often help the patient to understand how excessive anxiety may cause flare-ups of G.I. symptoms.

A disproportionate number of patients seen by the general practitioner suffer from functional disorders, as do more than half of those seen by the gastroenterologist.* Where milder cases may respond to counsel-

ing alone, if symptoms are severe and disabling to any degree, a suitable regimen may include medication to reduce the symptoms and the excessive anxiety that often provokes these distressing symptoms.

In these cases, Librax as an adjunct can greatly contribute to the course of therapy. Its dual action can offer relief of both painful symptoms and excessive anxiety, because each capsule contains 5 mg chlorthalidone HCl and 2.5 mg clidinium Br. The antianxiety action of Librium® (chlorthalidone HCl) makes Librax exceptional among drugs for certain gastrointestinal disorders associated with excessive anxiety; the clidinium bromide (Quarzan®) component furnishes dependable antispasmodic action. Dosage is flexible; it may be adjusted according to your patient's requirements within the range of 1 or 2 capsules three or four times daily, up to 8 capsules daily in divided doses.

An adjunct in anxiety-related upper functional G.I. disorders

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Each capsule contains 5 mg chlorthalidone HCl and 2.5 mg clidinium Br.

*Rome HP, Brannick TL: Orientation and mechanism of functional disorders: clinicophysiological correlation, chap. 133, in *Gastroenterology*, edited by Bockus HL, Philadelphia, WB Saunders Company, 1965, p. 1116

pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potent sedating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlorthalidone hydrochloride is used alone, drowsi-

ness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlorthalidone hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Doctors' Debate

MEDICAL TRIBUNE frequently receives extensive and well-documented communications from physicians on current subjects of controversy or those of great current medical interest. We invite contributions in these areas for presentation in this new feature.

The Edelin Case: Pros and Cons — Mostly Cons Among Letter-writers

Decadent Thinking?

Your editorial (MT, Mar. 12) reflects the decadent thinking of our society. Dr. Edelin is as guilty of homicide as I would be if I would hold your head in the swimming pool until you drown, which may not be such a bad idea after the editorial you have written. I am shocked and dismayed by the conviction of Dr. Edelin too, only in that he did not get a sentence commensurate with the crime which he has committed. When a physician deliberately drowns a baby, he can never be called innocent, no matter how you circumvent or define the term innocence or guilt. The plain fact of the matter is that drowning a baby is murder under any circumstances.

I also fully agree in the woman's right to have a baby if she so desires. However, if the baby is present in her house or in her uterus, she does not have the right to kill it for her convenience or for any other reason. Murder, by any name is murder.

You have misrepresented the "right to life people" by saying the prescribing of oral contraceptives is a potential charge of manslaughter. The right to life people, with whom I am familiar, do not make any stand on the contraindications whatsoever and feel that the problem can be solved by limiting conception, rather than killing of babies.

I certainly hope that Dr. Edelin's conviction will begin to turn the tide of justice back towards a more life respecting attitude. You also stated you are against suicide but would not deny a person the right to take his own life if he believes that would give dignity and peace to his death. I think before we condemn a fetus to a brutal and inhumane death, we ought to ask him, that is, the fetus, if he desires to live or die. When we are capable of doing that and when we can get his consent, then we can allow abortion on demand. The demand can be made not by the mother, but by the baby, whose life is at stake.

PARNELL M. DONAHUE, M.D.
Hartford, Wis.

A Lie-Detector Test?

Regarding the Edelin article: the whole case seems to boil down to the word of Dr. Enrique Gimenez-Jimeno against the word of Dr. Kenneth C. Edelin.

It seems absolutely incredible to me that Dr. Edelin, in the presence of a physician whom he knew to be opposed to abortion ("Could not leave" [because] Dr. Penza and Dr. Edelin were going to abort a fetus he thought might be viable, so he made a point of observing the hysterotomy"), would so obviously "insert his" entire hand "into the uterus and make the vigorous motion designed to detach the placenta."

"Then," he said, "with his hands still inside the uterus but not moving, Dr. Edelin waited for at least three minutes" while watching the operating room clock across the room."

I wonder if Dr. Enrique Gimenez-Jimeno was required to take a lie detector test, and if not, why not?

WALTER W. STOLL JR., M.D.
University of Kentucky
Lexington, Kentucky

When Life Begins?

The following is a simple, straightforward, honest, scientific explanation of when my and your life began. It is not a Papist, Mormon or Orthodox Jewish interpretation—just cold logical indisputable facts!

When a female egg is fertilized by a male sperm an entirely new and separate individual is conceived. This is the period of conception or, more simply, the "coming together." The new individual has 46 chromosomes, half from the mother and half from the father, which unite in a very unique manner making this individual separate and distinct from both the mother and the father, yet with hereditary characteristics of both. The chromosomes determine the color of your eyes, the color of your skin, etc. Following conception, begins the greatest growth period of your life until your natural death.

Are you a human being? When your mother was expecting a child, she was expecting a human being. She did not have a dog nor a cat. Dogs have puppies and humans have children. There is no other way. Are you a being? Yes, being is the nominative of the verb "to be." You are living from the time of conception, otherwise, how could you grow and why would it be necessary to kill you if you are not living?

The Supreme Court said that if life began with conception, then abortion would be homicide. They then proceeded to ignore the facts and write their own infamous abortion decision. I know when life begins and now you do too.

JOHN HENRY ROWLAND, JR., M.D.
Jacksonville, Fla.

Surgical Justification?

I am amazed at the mass of printed and vocal medical opinion giving the impression that the medical profession in general feels Doctor Edelin was "doing his duty."

First off, probably a majority of doctors do not agree with abortion at any stage. From a scientific standpoint a fetus three months in utero is as alive as an infant three months out of the uterus.

Regardless of that point, with all of the tissue committees, review committees, etc., involved in preventing

unnecessary operations, will you please explain to me the surgical justification of a Cesarean section done solely for the purpose of destroying a fetus in utero? A pregnancy at that advanced stage is clearly a uterus at term or approaching term. It is a major operation requiring considerable justification by medical review committees when performed for the purpose of delivering a normal term infant. How can you justify such a procedure for the destruction of an infant?

Please be advised that I for one have no medical or personal sympathy for Doctor Edelin. I think his act represented a crude, callous, materialistic thing that darkens the proud history of medicine's fight to preserve life.

Finally, as a surgeon, I do not think the operation was justified. It would have been less a threat to the mother's life to allow her to deliver normally and then to choke the baby to death.

JAMES T. JACKSON, M.D.
Dickson, Tenn.

Thanks to Medical Tribune

I wish to thank you for providing for the medical profession, your MEDICAL TRIBUNE.

Your recent editorials, and especially the one on "It Can Happen Here—Now," (MT, Mar. 19) have been immensely helpful. Your approach is straight-forward, systematically presented, and clear and concise conclusions, and especially appreciated by me.

... we have not had the experience in knowing and applying the admonition from the Mishna—"know how to answer the epicurean"—i.e., the non-believer.

Again, our heartfelt thanks...
HAROLD M. SPINKA, M.D.
Chicago

Abortions for Money

With reference to your statement in the 19 March issue of MEDICAL TRIBUNE, "Any physician can 'keep covered' if he lets self-interest outweigh his social conscience and sense of humanity and performs no abortions," let us please get a couple of things straight. First, in 99+ per cent of the U.S., self-interest dictates doing abortions, not refusing to do them. Boston juries are enormously atypical, and even there, the vast majority of feticide artists are prospering. There and elsewhere, twenty minutes of work nets well over \$300, as a rule. Considering the brief pre- and post-operative responsibilities, abortion pays better than neurosurgery, hour for hour. Small wonder that it has now become the second-most-commonly-performed operation in this country and threatens to become #1.

Secondly, I feel you do grave injustice to me and to the others who feel as I do when you suggest that social conscience and sense of humanity lead one to kill fetuses. It is precisely my conscience, social and otherwise, and my sense of humanity, which stays my hand. I am not a member of a church which proscribes abortion. I simply feel that nothing short of saving life can justify the taking of it.

In the future, please try to maintain a sense of fair play when editorializing

against those whose views do not match yours.

THOMAS BLAIR CARLETON, M.D.
Gunnison, Colo.

Antitrypsin Deficiency Commonest in Whites

Medical Tribune Report

NEW YORK—Preliminary data from a study of 917 California seventh-graders reinforce the suspicion that Caucasians are at greatest risk of both an inherited deficiency of alpha₁ antitrypsin (A₁ AT) and the emphysema with which it has been linked, according to Dr. Jack Lieberman, of City of Hope Medical Center, Duarte, Calif.

In the first Julia M. Jones memorial lecture, sponsored by the New York Lung Association, he reported that all 25 of the students found to have deficiencies of A₁ AT were Caucasian, as were nearly 90 per cent of those discovered to have variants of A₁ AT molecules.

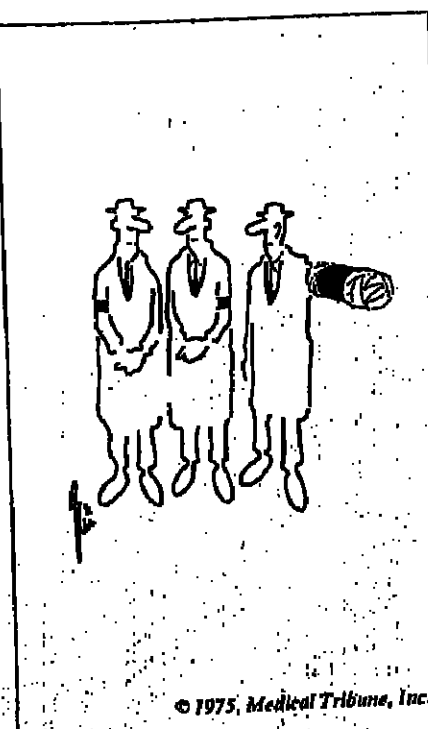
Dr. Lieberman also reported that to date, 19 families of students with severe or intermediate deficiencies have been tested, and that of 66 family members, 35, or 56 per cent, have been found to have deficiencies. He commented that the testing of family members of young people known to have A₁ AT deficiency offers hope for discovering potential emphysema victims before they develop clinical disease.

Dr. Lieberman stressed the importance of warning persons with the deficiency against smoking. Many studies suggest that emphysema may be prevented in those with intermediate deficiency "despite their unusual predisposition," he said, and the heterozygotes detected in the California screening program were counseled about the meaning of their inherited trait and told that they must not smoke cigarettes if they wished to reduce their chances of developing emphysema.

Gift to Cancer Center

Medical Tribune Report

NEW YORK—Three members of the Rockefeller family have agreed to contribute \$4,950,000 to the building program and \$1,000,000 for research at Memorial Sloan-Kettering Cancer Center here.



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Pathologist Says Americas Knew TB 800 Years Before Columbus' Arrival

Medical Tribune Report

NEW ORLEANS—You can't blame Christopher Columbus or the Viking explorers for the introduction of tuberculosis into the New World—the disease was already here nearly 800 years before Columbus came, according to a University of Virginia pathologist.

In fact, said Dr. Marvin J. Allison, tuberculosis was common among the Incas and other natives of the Americas.

He told a meeting here of the International Academy of Pathology that there are numerous examples of primitive art in North, Central, and South America depicting the familiar hunchback suggestive of Pott's disease, and

exhibited a picture of the fire god of the early Mexicans, Huehue Teotil, as representative of possible bone lesions of tuberculosis.

Aside from art, Dr. Allison noted that the mummified body of an eight-year-old Inca boy, shown by radiocarbon dating to have died about 700 A.D., provided tissue samples proving tubercle bacilli in lung, liver and other organs.

Lesions have been demonstrated by x-ray in other mummies, he added, one of them excavated last year by himself and Peruvian associates in the Valley of Pisco, Peru. In all, he and scientists of the Museum of Inca, Peru, have studied about 100 mummies, he said.

Ceramic figure of early Mexican fire god Huehue Teotil shows that characteristic lesions of tuberculosis of spine were known long before Columbus.



EDITORIAL CAPSULES

... brief summaries of editorials or comments in current medical and scientific journals.

The Ideal Physician

... in J.A.M.A. [228:1117, 1974], Dimond highlighted the desirability as well as the difficulty in selecting scientifically qualified medical students possessing the personal quality of compassion—a generally accepted characteristic of the ideal physician.

... A recent student-teacher clinic provided a simple example for evaluating student humanism, or its potential. A child neurologist and I (a child psychiatrist) were teaching four medical students the key diagnostic features of a mongoloid child. As each of the students examined the child and her epicanthal folds, noted the simian lines across her palms, demonstrated the laxness of her joint ligaments and her muscular hypotonia, one of the students spoke up spontaneously: 'Shouldn't we have washed our hands before examining the child?' He was concerned about the sudden and massive application of bacteria, etc., by 12 hands holding, flexing, and rubbing over the nearly naked baby. His sensitive concern was for a possible consequence secondary to the primary cognitive examination activity itself. . . .

"This example is from the same cloth as that of the physician who warms the stethoscope, takes the time to explain in advance unfamiliar sensations to expect during an examination, or tells a patient that crying with relief is a beautiful thing—and then comfortably allows it to happen. . . .

"The one common personality thread found in the fiber of an ideal physician may be this educated sensitivity, this sympathetic resonance with the patient, which does not affect the physician's objective decision making as much as it affects his style and manner of rendering his decisions or recommendations." (Editorial, Richard E. Davis, M.D., Am. J. Psychiatry 132:3, Mar. 1975)

Economics and Health

"Low man on the societal 'priority totem pole' is health—even in good times. Now, with inflation and recession to bear, the low man will be sacrificed. Maintaining good health through preventive medical practices, or seeking early medical care, becomes something which must be temporized. Man's inherent disposition to be concerned, to be responsive, becomes instead, indolent.

"When a nation's economy is historically strong, the preventable physical and mental ills of society decline to the point where they may be considered quiescent. During periods of inflation and recession, these ills will begin to gestate and, long after the nation's economic convulsion, will exacerbate once again.

"Public health practitioners nationwide must double their efforts to prevent this future shock. NOW IS THE TIME." (Editorial, Ben Chalke, Amer. J. Public Health, 65:306, March, 1975)

Developer of 'Heimlich Hug' Elucidates Physiologic Basis

Medical Tribune World Service

MONTREAL—The Heimlich maneuver—the forceful hug employed to try to pop food out of the mouth of a choking person and prevent death due to "cardiac coronary"—produces an average ejected air flow rate of 205 L. a minute and an average pressure of 31 mm. of mercury, in healthy adults.

This physiologic basis for the maneuver was presented here to the Society of Thoracic Surgeons by the developer of the technique, Dr. Henry J. Heimlich, of the department of surgery and anesthesiology of the Jewish Hospital, in Cincinnati.

The physiologic findings, he said, "account for the clinical observation that a bolus which is totally or partially obstructing the airway is forcefully ejected by the maneuver."

Applied to Drowning Victim

Dr. Heimlich added that similar factors (substantial air pressure and the expelling of a large volume of air from the trachea at a high flow rate) "are probably responsible for the expulsion of water from the lungs when the method has been applied to a drowning victim."

A person choking on food is "in a phase of normal tidal respiration," Dr. Heimlich explained, "... and not likely to be swallowing food at the end of a maximum expiration." Therefore, there is a portion of the tidal air plus the entire expiratory reserve volume available for ejecting the bolus of food.

Here's how Dr. Heimlich describes his maneuver:

● When the victim is standing or sitting, stand behind him and wrap your arms around his waist. Make a fist with one hand and grab it with the other. Place your fist above the victim's navel and below his rib cage, and press it forcefully into his abdomen with a quick upward thrust. Repeat several times if necessary.



Application of the Heimlich maneuver to aid a choking person when victim is standing, above left. Top right, position of rescuer's hands for standing victim. Center, demonstration of maneuver with the victim supine. Bottom, position of rescuer's hands for supine victim. Quick upward thrust into abdomen is made.

● When the victim is lying on his back, face the victim, kneeling astride his hips. With one hand on top of the other, place the heel of your bottom hand on the victim's abdomen slightly above his navel and below his rib cage. Then press forcefully into the victim's abdomen with a quick upward thrust, repeating if necessary.

Children have less air volume, Dr. Heimlich said, but he added that he has gotten reports of successful use of his maneuver in children whose ages ranged from nine to 15.

In children, he said, a smaller diameter of the trachea causes increased resistance to air flow, resulting in adequate pressure despite the fact that a lesser volume of air is expelled.

"The anatomic basis for the function of the Heimlich maneuver has been established by... [this] observation," Dr. Heimlich said: "With a patient in the lateral position during thoracotomy, pressure applied by the surgeon's fist upward into the abdomen below the rib cage is seen to cause the diaphragm to rise several inches into the pleural cavity."



Family Role Detected in Childhood Bronchitis

Medical Tribune World Service

ROTTERDAM, NETHERLANDS—Family influences including smoking appear to have a correlation with childhood respiratory disease, a British epidemiologist, Dr. John Colley, reported to the WHO Working Group on Management of Respiratory Diseases in Children meeting here.

Discussing his own recent research and that of others, Dr. Colley said that in one study involving over 10,000 children aged 6 to 10 it was found that 26 per cent of children with a bronchitic parent or siblings had a history of bronchitis, compared to 16 per cent in children without this background.

Dr. Colley, who is reader in pediatric epidemiology at the London School of Hygiene and Tropical Medicine, said the nature of the association is not yet clear. It may be due to a genetically determined susceptibility to respiratory disease in either or both parents, to the sharing of an adverse home environment, or to the transfer of respiratory infection from parent to child, he said.

The smoking habits of parents also correlate strongly with respiratory problems in children. Another study, of children aged 6 to 14, which was conducted in 1971 showed a cough prevalence three times higher where both parents produce winter morning phlegm. In a study last year in which follow-up was completed of 2205 infants and their families over the first five years of life investigators found that the risk of contracting pneumonia or bronchitis doubled for children whose parents smoked over 24 cigarettes a day.

It is clear from the investigation that "passive smoking" by the child has some effect, Dr. Colley commented. However, this seems to be most important in the first year of life.

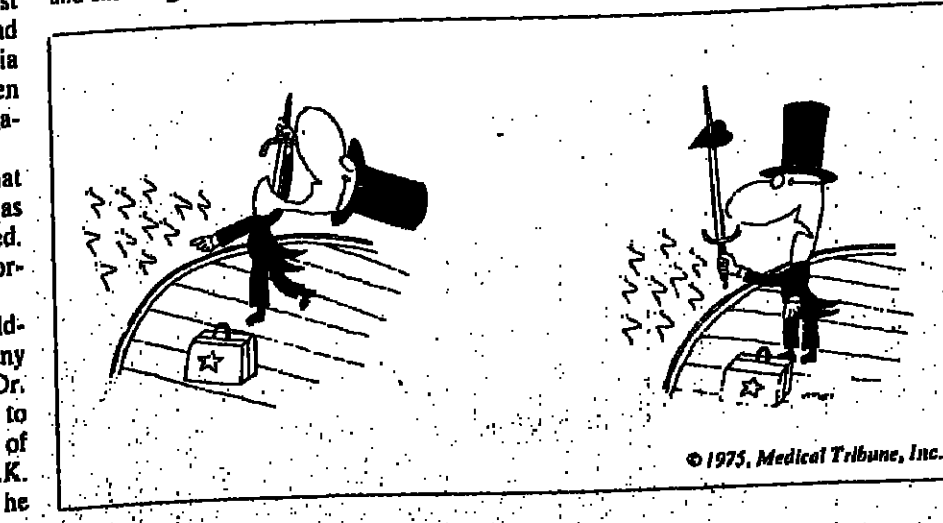
Some pediatricians doubt that childhood respiratory experience has any bearing on disease in later life, but Dr. Colley produced evidence pointing to such a link. Discussing a follow-up of the cohort of children born in the U.K. in one week in 1946 to the age of 25, he

noted that during the first two years of life both social class and air pollution influenced the incidence of lower respiratory tract illness. Incidence rose in step with air pollution, and was higher in the children of manual workers than in those of non-manual workers.

At the age of 20, the cohort were questioned on respiratory symptoms and smoking habits. Cigarette smoking

was found to have an important effect on chest symptoms; a chest illness under the age of two also had a somewhat smaller effect. Air pollution and social class, however, did not appear to be significant at the age of 20 or 25.

Dr. Colley suggested that smoking by parents operates at two levels: by increasing the possibility of infection being transmitted by cigarette-smoking parents' coughing and producing phlegm, and by "passive smoking" by children under one year.



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Space age microbicidal power BETADINE ANTISEPTICS

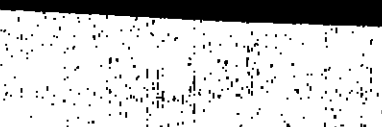
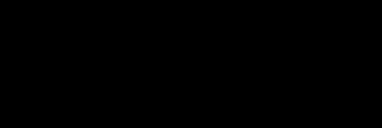
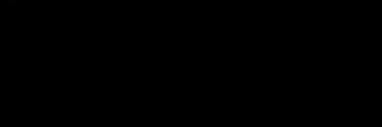
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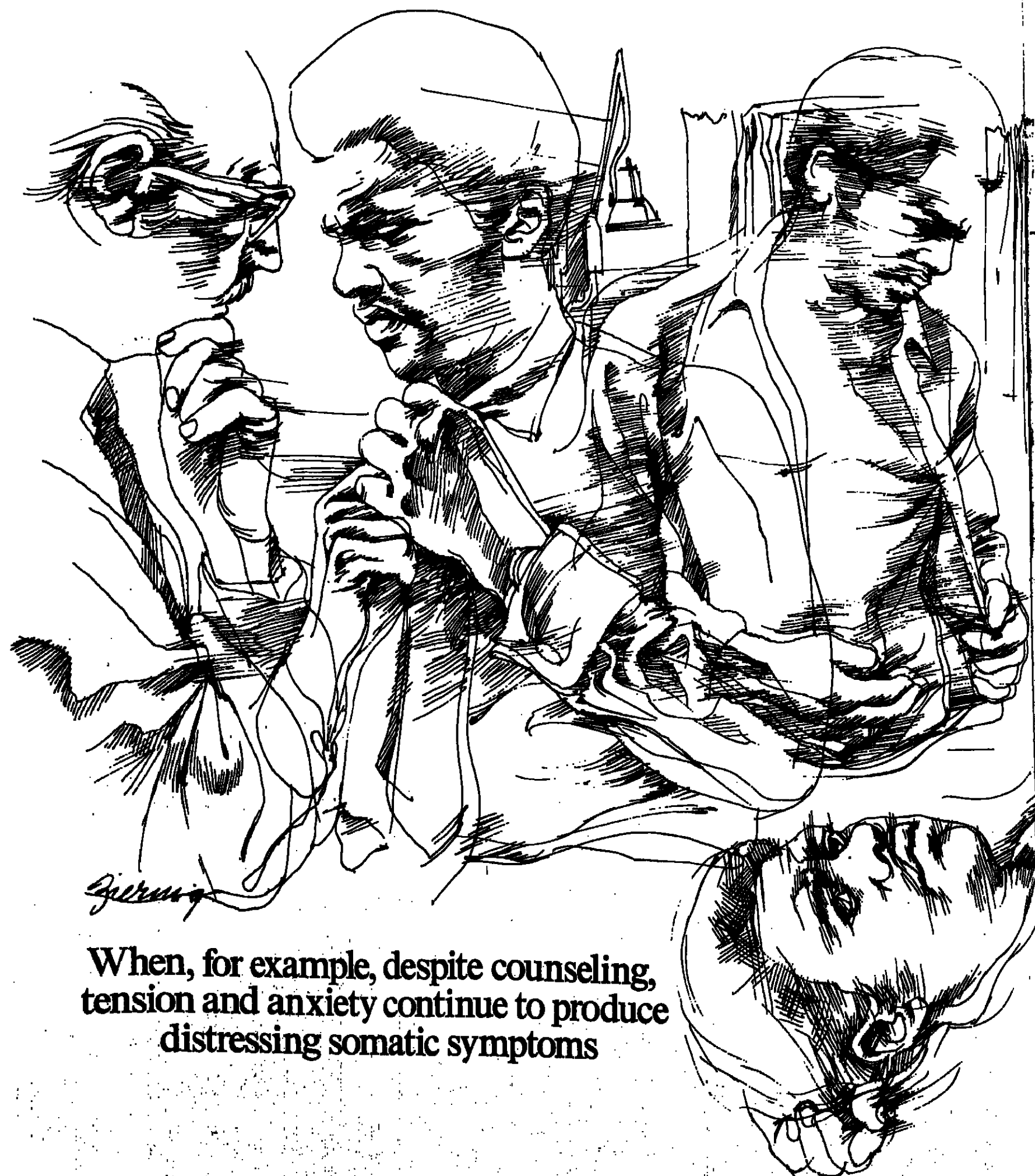
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed;

drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other anti-depressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over-sedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Wednesday, May 7, 1975

MEDICAL TRIBUNE

11

The Only Independent Weekly Medical Newspaper in the U.S.

Medical Tribune

and Medical News
Published by Medical Tribune, Inc.

What Goes On?

THE traditional rights of physicians have of late been severely rocked by the riptides of conflicting commercial and governmental economic activities. One therefore begins to look with suspicion at actions whose purposes cannot be discerned upon their surface.

The recent resolution of the Drug Research Board (National Academy of Sciences) regarding prescription practices is one such case in point. The mystifying situation surrounding this resolution was further compounded by another manifestation of the recent rash of irresponsible, inaccurate press releases issued by official or nonofficial governmental bodies and medical publications. The province of interest of a Drug Research Board would, if its title were indicative, appear to be research on drugs. The Board's relationship to the National Research Council and the Assembly of Life Sciences would suggest also that its province was in the area of the life sciences and not economics or medical politics. In the light of the above, one examines the five points of a resolution passed on October 25, 1974, in Washington, D.C.

The first "Whereas" related to the generalized truism that "the patient's welfare should be the ultimate goal of statutes and regulations concerning drug product selection."

The second "Whereas" acknowledges that the physician "must have the ultimate responsibility and authority in drug product selection." Agreed. Why this should need restatement at this time is not clear and suggests that something lay behind the resolution.

The third "Whereas" stated, "The pharmacist may, in some situations, have greater knowledge of drug products than other health professionals, including knowledge of both quality and costs." This is a baffler. Here the Drug Research Board gets itself involved in what may be a debate as to the traditional relationship between physician and pharmacist. What this has to do with drug research is not clear.

The fourth "Whereas": "It is appropriate that decisions with regard to the choice of drug products be made by the health professional possessing the greatest amount of information involved in the particular selection in question, with the attendant accountability" seems to us to be a reaffirmation of the physician's preeminent position and responsibility in therapy.

The fifth point is, "Resolved, that the physician, having selected the chemical entity to be used for therapy, should be required either to delegate to the pharmacist, or explicitly to retain to himself, selection of the particular drug product to be dispensed and received by the patient." It would seem to be a resolution as unnecessary as it was uncalled for from the Drug Research Board. It is not clear why the Drug Research Board should come to such an affirmation. Does it have any

research suggesting that there was a need for such a resolution? What kind of clinical orientation leads to a conclusion that every drug product is a "chemical entity"?

Every physician today clearly indicates whether he explicitly "retains for himself the selection of a particular drug product to be dispensed" or whether he delegates that choice to the pharmacist by the manner in which he writes his prescription. The physician who prescribes a trademarked drug has explicitly selected the specific substance and manufacturer whose therapeutic agent he wants dispensed. The physician who writes a generic prescription clearly is delegating to the pharmacist selection of one of several drugs.

It would seem, therefore, that the resolution of the Drug Research Board, if it did more than affirm the existing situation, had another purpose. If that purpose was to foster or advance the repeal of antitrust laws, then it would seem that a scientific body was lending its name and prestige for economic or political purposes to an action which would not only change the traditional relationship between the professions of medicine and pharmacy but erodes the major protection which exists—that a patient gets what his physician prescribes, and not a substitute. If the intent of the Drug Research Board was to protect patients in respect to their receiving precisely what the doctor wanted—either a specific drug or a generic drug, then it should have gone on to endorse the antitrust laws which exist to prevent any deviation from the intent of the professional who best knows the patient and who has the responsibility for his treatment. That intent can and is clearly expressed today in existing practice—and its fulfillment made possible by the teeth in the penalties that exist in the antitrust laws.

The reasons for the resolution of the Drug Research Board, the reasons for the erroneous press release which accompanied it, the reasons for the statement clarifying the October 25th resolution and the confusion and conflict which have followed have all resulted from an action whose intent would appear to be at this juncture inexplicable, to put it mildly. The medical profession needs clarification and confirmation that its traditional prerogatives are not being undermined by quasi-governmental and other bodies whose intent appears to confirm practices which already exist but whose effect would be to alter and destroy existing relationships—a goal which is not fundamentally scientific nor professional but one which is economic and which in effect challenges the rights and responsibilities of physicians.

A.M.S.



"I don't have any confidence in him either, and he's my husband."

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LETTERS TO TRIBUNE

An Endorsement

I wish to commend Dr. Sackler in a general way for the marvelous editorials he has given us for a long time in MEDICAL TRIBUNE, and wish to heartily endorse the urgent message he has brought to us in the past two issues relating to the Edelin case and all of its implications.

I hope he will continue vigorously to call attention to these matters and their ultimate meaning for all of society, but particularly to the Medical profession. He has my heartiest congratulations.

CHARLES F. MORRELL, M.D., FACS
Long Beach, Calif.

No-Fault Insurance

Congressman Hastings' criticism of Senator Inouye's "No Fault Bill"—quoted in MEDICAL TRIBUNE (April 2)—is a gratuitous insult to the medical profession. One of his criticisms of this proposed legislation is that doctors won't "have to be concerned any more as to the quality of medicine since there's automatic coverage." There are many snide implications in such a statement, not the least of which is that there is better qualitative medicine when doctors have the fear of malpractice as a stabbing threat.

Note though how the real threat of eliminating the contingency fee in this bill brings him to colleagues defense by raising the attenuated vis-a-vis of States vs. Federal jurisdiction. Like "separate but equal," jury service, "voting eligibility?"

HARRY E. BELLER, M.D.
Miami, Fla.

AT&A? When?

I read with interest the recent article, "When to Do T & A? 30 Surveys Fail To Resolve Issue" (MT, April 2). Dr. Feldman and his colleagues are to be commended for trying to make some sense out of the morass of studies, allegations, diatribes, half-truths and quasi-religious beliefs surrounding this procedure. However, any retrospective study of a group of largely retrospective studies, no matter how sophisticated the point-scoring, is doomed to inconclusiveness from the start. The fact is that almost everything about the operation had undergone much change in the past 50 years—who does

it, how it's done, whether adenoidectomy or tonsillectomy or both are done the varying indications, etc., etc.

The wholesale "family-plan" T & A's done, the varying indications, etc., etc. to mastoiditis in 1920 bear little resemblance to the selective adenoidectomy, myringotomies, and middle ear intubations done today after multiple ear infections and treatment—refractory seromucinous otitis media. Like the problem of duodenal ulcer, treatment of adenotonsillar-cum-middle ear disease has seen different approaches, ranging from "conservative" to surgery to radiotherapy, and while some of these approaches are "warring in elegance of rationale," the problem remains.

I was not disappointed in my expectation of the clarion call from Academe—for "a prospective, randomized, controlled clinical trial quantifying outcome by objective techniques." It has a fine ring to it, it is manifestly desirable, and it is totally impossible in the real world. Given a child who can't breathe possibly because of adenoidal hypertrophy and who can't hear because of serous otitis media, who is to tell him that he will be a randomly selected control, and be treated "conservatively"? At what point does surgical treatment become "conservative" and non-surgical therapy "radical"? Each case must be individually scrutinized and treated to the best of the physician's ability, with the best then available treatment. To consign even one child to the vagaries of a statistical Kismet is to awaken echoes of the Tuskegee Study.

The answer is that there are no easy, consistently reproducible answers. An individual analysis by a knowledgeable and competent physician still remains the most dependable approach to this problem.

WILLIAM F. FLYNN, M.D.
New Rochelle, N.Y.

On Dispensing Drugs

For a long time I have been reading Dr. Sackler and enjoying it, but I believe his editorial, "On the Dispensing of Drugs" (MT, April 2), is the best thing I have seen.

Your well done article is plain enough that legislators and the public can understand it.

My thanks!
MAL RUMPH, M.D., F.A.C.S.
Fort Worth, Tex.

How—and Whether—to Provide Complete Cardiac Care in a Community Hospital

Medical Tribune Report

HOUSTON—Guidelines for the community hospital on how—and whether—to embark on programs of cardiac catheterization and cardiac surgery were outlined here to the American College of Cardiology by physicians whose experience with complete cardiac care in such a setting now totals nearly five years.

Staff members at Methodist Hospital in Lubbock, Tex., said they believe their results demonstrate that a community hospital can provide quality service plus the advantages of home surroundings, lower costs, and less disruption for families.

But the Lubbock group also emphasized during the symposium it presented that community hospitals should not attempt a full range of cardiac care unless specific criteria can be met.

Patient Population Size Vital

One essential condition is a patient population big enough to warrant the program and permit specialists to maintain their skills, according to Dr. Joe O. Arrington, a staff cardiologist and chairman of the symposium.

Equally vital, in his opinion, are community cooperation, a "well-motivated" administration and hospital board, and a "cadre of properly qualified and trained personnel."

The cardiac catheterization laboratory at Methodist Hospital opened in 1970 and an associated cardiac surgical program was established later that year.

Delayed Correction Of Cardiac Rhythm Encountered in 3%

Continued from page 1

converted spontaneously to normal sinus rhythm.

In one case, Dr. Duvernoy said, there was possibly atrial dissociation, with one atrium continuing in fibrillation while the other was in sinus rhythm, but the leads used did not permit absolute proof. "The mechanism of delayed conversion in the other cases remains speculative," Dr. Duvernoy continued.

It has been shown that small energy shocks falling into the atrial vulnerable period will cause atrial fibrillation, Dr. Duvernoy said, and this is apparently an unstable mechanism that then reverts spontaneously to normal rhythm. It's also known, he said, that direct current shock causes an intense stimulation of sympathetic and parasympathetic receptors in the heart, causing a release of catecholamines and acetylcholine.

"These substances may influence the cardiac rhythm for a period of time following direct current shock and have been linked to the occurrence of post-shock arrhythmias," he said. Another possible mechanism, Dr. Duvernoy noted, is a partial depolarization of the atria following atrial stimulation with normal sinus rhythm occurring when a critical amount of synchronized atrial fibers is reached.

More than 3,000 coronary arteriograms and some 900 heart operations have been performed at the institution, which now has 549 beds.

It takes a sizable staff to handle an annual volume of 1,000 coronary studies, Dr. Samuel M. King reported. He and Dr. Jay B. Jensen, who have been doing the cardiac catheterizations since the start of the program, agree that a basic crew of four people is advisable in addition to the performing physician.

These include the nurse in charge, a laboratory technician to operate the multichannel recorder and carry out various determinations, a special x-ray technician, and an operating-room technician.

"There is no doubt that we could probably eliminate one of these crew members but it would be at the expense of efficiency and personnel fatigue," Dr. King said.

Both physicians stressed their belief that the angiographer should be skilled in two methods of performing coronary studies—the Sones technique, which they have used exclusively in about 95 per cent of their cases, and the Judkins technique.

"The most important aspect of any technique," Dr. King commented, "is to know which one to employ when."

Reviewing results of the first 3,000 coronary arteriograms, Dr. Jensen said that five patients had died as a complication of the angiographic procedure.

Four of the five fit a common pattern, he noted. They had unstable angina, together with symptoms and signs of left ventricular dysfunction; either total or subtotal occlusion of the right coronary artery; and nearly total obstruction of the left main coronary artery.

Extremely Poor Prognosis

"Even in light of these mortality statistics for severe left main coronary disease," he added, "we feel that aggressive management is indicated because of the extremely poor prognosis with medical treatment."

Dr. Jensen sounded a strong warning, however, against the performance of invasive cardiovascular studies at any facility lacking an adequate case-load, good clinical facilities, and angiographers with experience as well as sufficient training.

Another symposium participant, Dr. Donald L. Bricker, cardiac surgeon at the Lubbock hospital, included the same cautions in a how-to-do-it prescription for the community hospital thinking of a cardiac surgery service. His specific recommendations:

- Evaluate needs and resources. Find out how many patients referred for catheterization subsequently need surgery. Know what the hospital can provide (space, financial support, personnel). Determine community attitudes.
- "If people are opposed to the program, they'll later say 'I told you so' if anything goes wrong."
- Establish a cardiac catheterization laboratory with a fully qualified and trained cardiologist.
- Recruit a cardiac surgeon with demonstrated expertise—"not someone just out of residency." Make sure that this surgeon is familiar with all aspects of cardiac surgery, has essential equipment, and is allowed to build a team of



Staff at Methodist Hospital in Lubbock, Tex., believe their results show that community hospitals can provide quality cardiac catheterization, above, and cardiac surgery procedures with advantages of home surroundings and lower costs.

surgical assistant, nurse, anesthesiologist, and clinical perfusionist.

- Coordinate the intended program with the hospital administrator and a medical-surgical cardiopulmonary committee. Inauguration of cardiac surgery will require cross-training for in-house personnel, purchase of much equipment, modification of facilities, provision of special laboratory services, and blood bank support.
- Finally, don't underestimate the difficulties of setting up a cardiac surgery

program since "Murphy's law will prevail." Even the best surgeon can experience trouble, Dr. Bricker noted, and the community hospital that plans to set up a comprehensive program must remember that it cannot then pick and choose among cases.

"Being 'just as good' as a referral center is inadequate," he said. "If you break lines of referral, you have to provide something the center doesn't. That means greater convenience, less cost, better results."

F.G.

Better Understanding Urged Of Unique Stressors in Aged

Medical Tribune Report

NEW YORK—Improving the mental health of older people through counseling, preparatory training, utilization of skills, and treatment based on a better understanding of stress and aging was urged here by Dr. Stephen Nordlicht, Clinical Associate Professor of Psychiatry at Cornell University Medical College.

Stressors unique to the aged—the loss of loved ones, friends, position, income, health, and cognitive functioning—"are sufficiently severe to create serious consequences but can be ameliorated by the concerned physician's early assistance," he told the 169th annual meeting of the Medical Society of the State of New York.

Recognizing stress and the physiological factors involved in aging—"the breakdown of neural and endocrine integrative function, dropping out of functional units in vital organ systems, and loss of functional capacity of many cells in the body"—are the physician's prime concerns in dealing with older patients' problems, Dr. Nordlicht said.

"Priority should also now be given to acquiring a greater understanding of how the individual adjusts to the various changes in life," as well as how these life events create stress, he said.

Eradication of mistaken beliefs, particularly the "destructive" philosophy of remaining youthful at all costs,

is also the physician's responsibility, he continued. This philosophy, he said, leads to the rejection of the older person and also to anxiety at the thought of aging.

"The mistaken belief that for most older people mental illness is inevitable" must also be changed through physicians' efforts, Dr. Nordlicht said.

He also made these points:

- Utilizing the skills of older people "will not only add to the economic strength of the community but also serve to dissipate the feelings of isolation and rejection. Probably it is not yet fully comprehended how dependent we are on our occupation for social acceptance."
- Preparatory training for growing old, similar to that for future mothers by obstetricians, should be carried out by qualified physicians. This would help the older person "to continue functioning independently and productively."
- The slowing of the perceptual and response processes is "bewildering, confusing, and painful" for the patient, and may lead to depression and even suicide. Help should be provided "when the stresses first begin, rather than delaying and then recognizing that we are too late."
- "Medical advances can only be successful if we also resolve the accompanying socioeconomic and behavioral problems. Longevity alone is no longer the only goal."

M.H.

For Unwary Homeowner, Spring Is Accident Season



EACH SPRING the sun shines, the rain comes down, lawns and shrubs grow, and homes need repairs after the storms of winters. Result: thousands of emergencies for physicians and hospitals. Many of the accidents involve teen-agers of children working around the home without adequate supervision. Some numbers give an idea of the scope of the problem—50,000 injuries each year due to power lawn mowers, 356,000 on stairs, ramps, and landings, and 183,000 involving glass doors and windows. These figures represent injuries serious enough to require the attention of a physician; many millions of minor injuries go without such treatment. The accompanying photographs illustrate some typical examples of accident-provoking conduct in home maintenance situations.

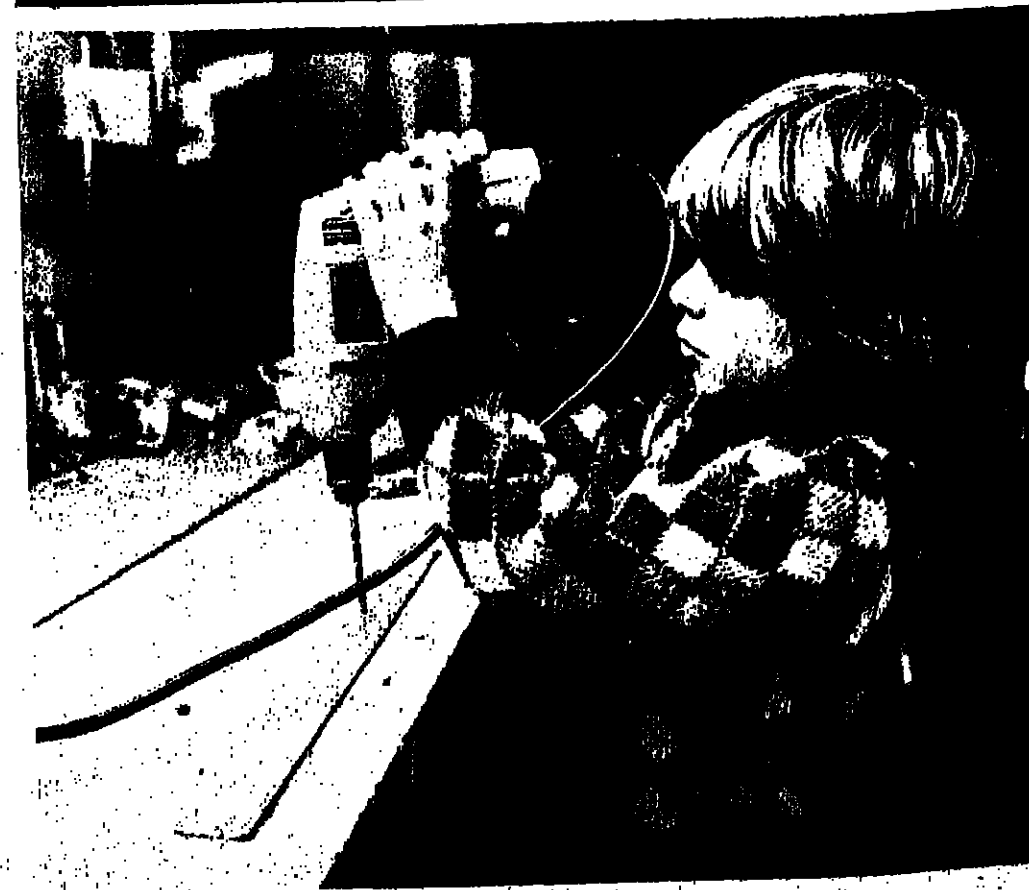


Not only should products containing poisons be kept out of the reach of young children, but also older children should be made fully aware of the caution with which such products should



be handled, above. Right, any use of ladders, especially around windows, should involve two persons—one to hold the ladder firmly. And no child should use a ladder unsupervised.

Dark stairs, above left, leading to cellars, garages, and storage areas frequently cause severe falls. Below left, power tools should be kept where young children cannot reach them. And teen-agers should work with unfamiliar tools only under close supervision. Below, power lawn mowers cause some of the most serious accidents. They should be operated with extreme care and only by those old enough to read and heed instructions and warnings.



We know Librium works. (chlordiazepoxide HCl)

We're still learning more about how and why.

Value of continuing animal research

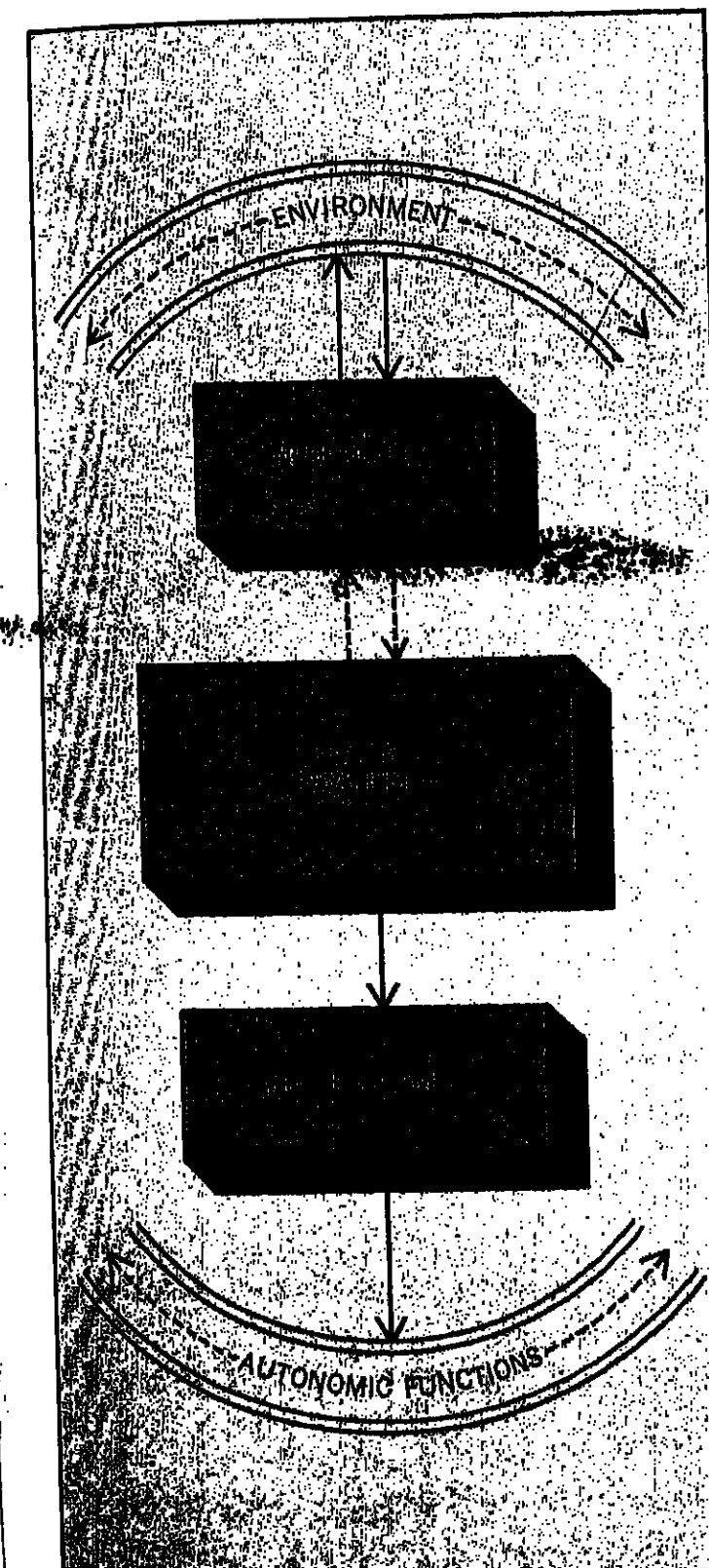
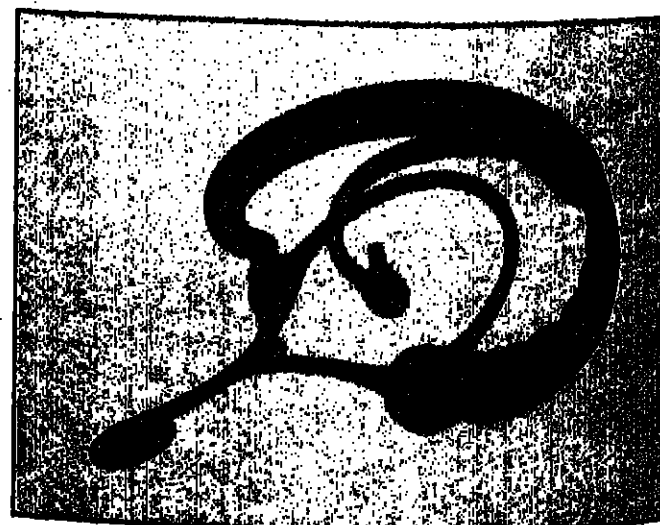
Clinical knowledge of Librium is extensive, yet its mode of action remains under continuing study. Data from animal experiments have been presented here for their intrinsic interest and because such findings often provide direction to new research, both experimental and clinical. However, conclusions from such studies may not always be extrapolated to humans.

Is the limbic system the "Librium (chlordiazepoxide HCl) system"?

A great deal of experimentation on various animal species suggests that the limbic system is the principal site of action of Librium. Thus, in freely moving cats with electrodes implanted in the brain, Librium 5 mg/kg i.p. slowed electrical activity in the hippocampus, amygdala and septal areas but not in the neocortex which was significantly affected only at higher doses.^{1,2} Current investigations on monkeys,^{3,4} however, indicate that other subcortical structures may be implicated in the effect of Librium.

Other investigators, through electrophysiologic studies⁵ in intact, conscious cats and monkeys, have demonstrated that chlordiazepoxide activates structures involved in the rewarding system—the preoptic area, lateral hypothalamus, septal region and hippocampal formation. At the same time, it appears to inhibit structures implicated in aversive behavior—the thalamic nuclei of the diencephalon and the midbrain reticular formation (MRF).

- References:
1. Schallek W, Kuehn A, Jew N: *Ann NY Acad Sci* 96:303-312, Jan 13, 1962
 2. Stornbach JH, Randall LO, Gustafson SR: 1,4-Benzodiazepines (Chlordiazepoxide and Related Compounds), chap. 5, in *Psychopharmacological Agents*, edited by Gordon M. New York: Academic Press, vol. 1, pp. 173-178
 3. Delgado JMR, Bruochitta H, Snyder DR: Psychoactive Drugs and Radio-Controlled Behavior. Film presented at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-6, 1971
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 5. Guerrero-Figueroa R, et al: Electrophysiological analysis of the action of four benzodiazepine derivatives on the nervous system, *ibid.*, pp. 489-511



Schema demonstrating hypothetical pathways of emotional activity and its related expression in laboratory animals.

Clinical significance of excessive anxiety

Anxiety, when inappropriate and immoderate, may not only have adverse psychological effects but may also cause various somatic disturbances. Reduction of excessive anxiety thus contributes to relief of anxiety-linked emotional and physical disorders.

Antianxiety action of Librium (chlordiazepoxide HCl)

The dependable action of Librium has been demonstrated in the relief of excessive anxiety and tension occurring alone or in association with functional and organic disorders—usually without adversely affecting performance. Librium is often used concomitantly, when anxiety is a contributing or complicating factor, with certain specific medications of other classes of drugs, e.g., cardiac glycosides, diuretics and antihypertensives.

Adjunctive use of Librium is recommended when counseling, reassurance or other nonpharmacologic measures alone are not considered sufficiently effective. When anxiety has been reduced to manageable levels, therapy with Librium should be discontinued.

Librium®
(chlordiazepoxide HCl)
5 mg, 10 mg, 25 mg capsules

ROCHE

We're still learning more about it
to make it more useful to you.

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other

CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions),

following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of child-bearing age requires that its potential benefits be weighed against its possible hazards. **Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or over sedation.

increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Para-

doxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and

oral anticoagulants; causal relationship has not been established clinically. **Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin

eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making

periodic blood counts and liver function tests advisable during protracted therapy. **Supplied:** Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

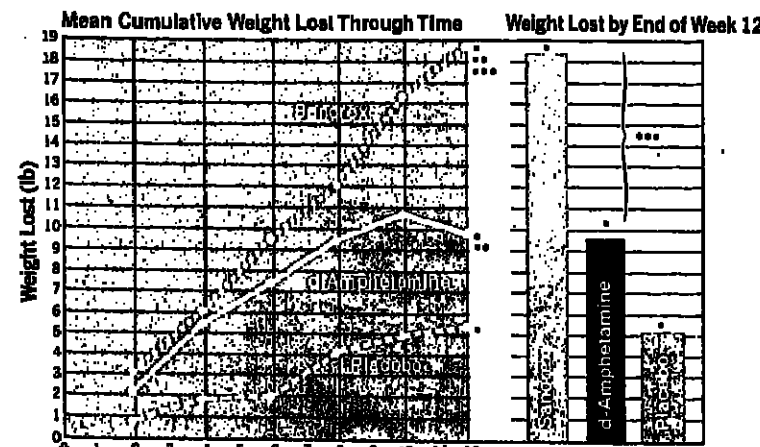
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MAZINDOL® IN OBESITY

TABLETS, 1 mg and 2 mg.



AS EFFECTIVE AS d-AMPHETAMINE



Weeks

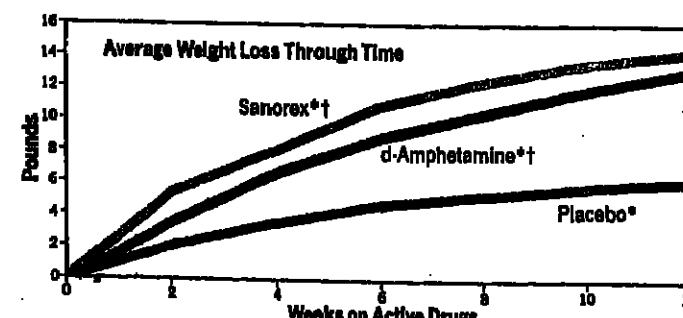
*Significantly ($p < .001$) greater weight loss than placebo from Week 6 through end of Week 12.

**Significantly ($p < .001$) greater weight loss than d-amphetamine from Week 6 through end of Week 12.

***Significantly ($p < .001$) greater weight loss than d-amphetamine from Week 10 through end of Week 12.

In a double-blind study¹ of 40 obese patients (all of whom completed the study), Sanorex (1 mg t.i.d.) was more effective than either placebo or d-amphetamine (5 mg t.i.d.) in helping patients lose weight.

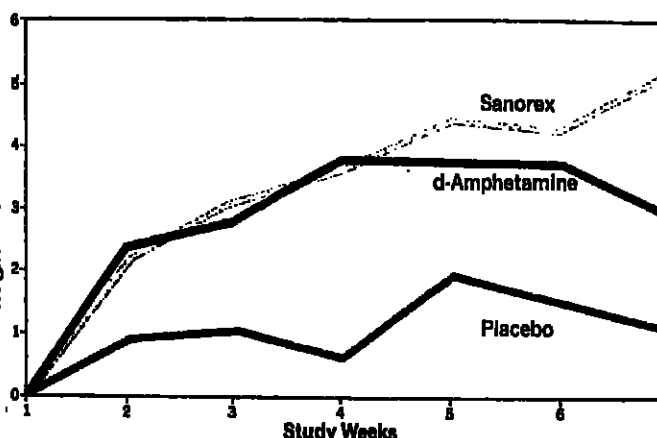
The 14 patients on Sanorex experienced a substantially greater mean weight loss—1½ to 2 lb/wk, as compared with 1 to 1½ lb/wk for the 14 d-amphetamine patients—throughout the 12-week phase of active medication. After the sixth week, the superiority of Sanorex became increasingly evident. And as treatment progressed, so did weight loss in patients on Sanorex—whereas after the tenth week, patients on d-amphetamine began to regain some weight.



Weeks on Active Drugs

*Significantly greater weight loss than placebo at each two-week interval ($p < .05$).

†Significantly greater average weight loss than placebo at each two-week interval ($p < .05$).



In a double-blind study² of 90 obese patients (59 of whom completed the study), Sanorex (1 mg t.i.d.) was more effective than either placebo or d-amphetamine (5 mg t.i.d.) in helping patients lose weight.

By the end of the third week of active medication, weight loss in the 20 d-amphetamine patients began to plateau, and by the end of the fifth week, these patients began to regain some weight. On the other hand, the 18 patients on Sanorex continued to lose weight throughout the six-week course of therapy.

In a double-blind study³ of 93 obese patients (all of whom completed the study), 30 patients received Sanorex (1 mg t.i.d.), 31 received placebo, and 32 received d-amphetamine (5 mg t.i.d.).

During the 12-week phase of active medication, patients on Sanorex lost an average of 14.1 lb, compared with 13.1 lb for d-amphetamine patients and 5.6 lb for placebo patients. Throughout the active medication phase, 63% of patients on Sanorex lost more than 1 lb/wk, compared with 38% of the d-amphetamine group and 29% of the placebo group.

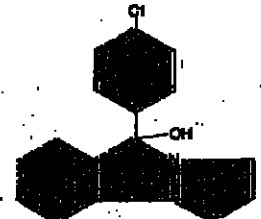
BUT WITH CERTAIN DIFFERENCES

Although the pharmacologic activity of Sanorex and that of amphetamines are similar in many ways (including central nervous system stimulation in humans and animals, as well as production

Different Chemical Structure



An important chemical similarity between amphetamines and all other prescription anorexants except Sanorex is the basic phenethylamine structure to which their differentiating chemical radicals are attached.



An important chemical difference between Sanorex and all other prescription anorexants is that Sanorex is an isolidole; it does not contain a phenethylamine structure.

of stereotyped behavior in animals), animal experiments suggest that there are differences. Sanorex also differs in basic chemical structure from amphetamines and all other prescription anorexants.

Different Neurochemical Action

Action of d-Amphetamine In animal studies, d-amphetamine (like intake of food) activates efferent neurons leading to appetite centers in the hypothalamus. Resulting release of norepinephrine activates the receptor neurons. Unlike food, however, d-amphetamine also suppresses norepinephrine synthesis. Thus, increasingly larger doses of d-amphetamine become necessary to produce an effect.*

Action of Sanorex (mazindol) After intake of food stimulates the release of norepinephrine from the efferent neuron, Sanorex blocks its re-uptake without disturbing normal synthesis and release.*

*The significance of these differences for humans is uncertain.

Simplicity and Flexibility of Dosage

Simple one-a-day dosage is facilitated by 2-mg tablets (taken 1 hour before lunch).

New flexibility (for the patient in whom 1 mg t.i.d. is preferred) is now facilitated by new 1-mg tablets (taken 1 hour before meals).

For Brief Summary, please see facing page.

SANOREX® (MAZINDOL)®

References

1. Kornhaber A: Problems and current concepts in the treatment of obesity. Scientific Exhibit presented at the New York State Academy of Family Physicians, 25th Annual Scientific Convention, Ithaca, N.Y., May 8-10, 1973.
2. DeFatta EA, Chaykin LB, Cohen A: Double-blind clinical evaluation of mazindol, dextroamphetamine, and placebo in treatment of exogenous obesity. *Curr Ther Res* 15:358-366, July 1973.
3. Vernice BJ: Practical considerations for managing obese patients: Initial interview and effective treatment in the office. Scientific Exhibit presented at the American Medical Association, 27th Clinical Convention, Anaheim, Calif., Dec 1-4, 1973.

Indications: In exogenous obesity, as a short-term (a few weeks) adjunct in a weight reduction regimen based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors.

Contraindications: Glaucoma; hypersensitivity or idiosyncrasy to the drug; agitated states; history of drug abuse; during, or within 14 days following, administration of monoamine oxidase inhibitors (hypertensive crisis may result).

Warnings: Tolerance to many anorectic drugs may develop within a few weeks; if this occurs, do not exceed recommended dose, but discontinue drug. May impair ability to engage in potentially hazardous activities, such as operating machinery or driving a motor vehicle, and patient should be cautioned accordingly.

Drug Interactions: May decrease the hypotensive effect of guanethidine; patients should be monitored accordingly. May markedly potentiate pressor effect of exogenous catecholamines; if a patient recently taking mazindol must be given pressor amine agents (e.g., levaterenol or isoproterenol) for shock (e.g., from a myocardial infarction), extra care should be taken in monitoring blood pressure at frequent intervals and initiating pressor therapy with a low initial dose and careful titration.

Drug Dependence: Mazindol shares important pharmacologic properties with amphetamines and related stimulant drugs that have been extensively abused and can produce tolerance and severe psychologic dependence. Manifestations of chronic overdosage or withdrawal with mazindol have not been determined in humans. Abstinence effects have been observed in dogs after abrupt cessation for prolonged periods. There was some self-administration of the drug in monkeys. EEG studies and "liking" scores in human subjects yielded equivocal results. While the abuse potential of mazindol has not been further defined, possibility of dependence should be kept in mind when evaluating the desirability of including the drug in a weight-reduction program.

Use in Pregnancy: In rats and rabbits an increase in neonatal mortality and a possible increased incidence of rib anomalies in rats were observed at relatively high doses. Although these studies have not indicated important adverse effects, the use of mazindol in pregnancy or in women who may become pregnant requires that potential benefit be weighed against possible hazard to mother and infant.

Use in Children: Not recommended for use in children under 12 years of age.

Precautions: Insulin requirements in diabetes mellitus may be altered. Smallest amount of mazindol feasible should be prescribed or dispensed at one time to minimize possibility of overdosage. Use cautiously in hypertension, with monitoring of blood pressure; not recommended in severe hypertension or in symptomatic cardiovascular disease including arrhythmias.

Adverse Reactions: Most commonly, dry mouth, tachycardia, constipation, nervousness, and insomnia. Cardiovascular: Palpitation, tachycardia. Central Nervous System: Overstimulation, restlessness, dizziness, insomnia, dysphoria, tremor, headache, depression, drowsiness, weakness. Gastrointestinal: Dryness of mouth, unpleasant taste, diarrhea, constipation, nausea, other gastrointestinal disturbances. Skin: Rash, excessive sweating, clamminess. Endocrine: Impotence, changes in libido have rarely been observed. Eye: Long-term treatment with high doses in dogs resulted in some corneal opacities, reversible on cessation of medication; no such effect has been observed in humans.

Dosage and Administration: 1 mg three times daily, one hour before meals, or 2 mg per day, taken one hour before lunch in a single dose.

How Supplied: Tablets, 1 mg and 2 mg, in packages of 100.

Before prescribing or administering, see package circular for Prescribing Information.

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One Man...and Medicine

ARTHUR M. SACKLER, M.D.
International Publisher, Medical Tribune



Mystification

Part II

The sophisticated misuse of simplistic approaches may arrest, it cannot advance, solutions to real problems, and there are real problems of addiction.¹ To single out the physician, his prescribing practices ["written into law as his exclusive prerogative"] and his "legal drugs," and to blame these and public and professional promotion, as Lennard et al do, is to disregard reality. Certainly biblical Lot's being drugged by his daughters was no consequence of psychoactive drug advertising. It is our impression that Hogarth's classic commentary on the devastation of gin preceded the advent of TV. The incredibly extensive use of bhang and marijuana in India and Africa and of derivatives of the poppy in the Middle East would be hard to correlate either with mass media promotion, pharmaceutical promotion, or physician prescription.

Lennard et al, in *Mystification and Drug Misuse*, touch on a subject of deep interest to me—the "epidemic" of hyperactive children or minimal brain damaged (MBD) children. My concern is heightened by my fear that MBD may have a large iatrogenic component, possibly related to the use of restricted diets, restricted salt, and diuretic agents in pregnancy; and to the deprivation of protein due to poverty or ignorance. For me, the primary focus should be the prevention of damage to mother and fetus—not a debate on the treatment of its consequences.

Data and Conclusions

I note Lennard et al's quote of Esly: "I have since found out from fellow pediatricians that parents are slipping the children sedatives too—they tell me it is quite common." As one interested in hard data, I object with equal vigor to the use of anecdotal material or distorted references whether it be in pharmaceutical promotion or in professional publications. Heaven knows, we have had enough debate on double blinds and statistical validity. Nonetheless, in evaluating any scientific document, the analysis of its data is, of course, obligatory.

Picture my mystification as to the following: I read on page 61 that Lennard et al studied "twenty-eight discussion groups in which one of the participants in each group had been administered 50 mg of chlorpromazine (a not inconsiderable dose)." Chlorpromazine is indicated primarily for the psychoses in much heavier dosages, with a clear admonition that it might take weeks to perceive an effect. Thus, understandably, we learn on page 62 that co-group members judged 45 per cent of placebo subjects to have received a tranquilizer and 10 per cent a stimulant; and as to the subjects on medication, 21 per cent were judged to have had none, and 28 per cent a stimulant.

Furthermore, "psychiatrists were quick to inform us who among the sub-

jects had in their opinions, received the active agent. They were more often wrong than not."²

Drugs and Group Interaction

From the above it would seem that one could only conclude that either 50 mg of chlorpromazine given to these subjects in this situation had no effect or, perhaps more properly, that no conclusions could be drawn. Nonetheless, on page 86 (referring to the same original report, same journal, same year, same volume and same pages—H. L. Lennard, L. J. Epstein, and B. G. Katzung, "Psychoactive Drug Action and Group Interaction Process," *Journal of Nervous and Mental Disease*, 1967, 145: 69-78) the authors state:

"In our research we studied the effect of a single administration of a phenothiazine drug on patterns of interaction in seven 'natural' groups, each of which contained three persons. Only one member of each group was given phenothiazine. We noted a decrease of activity on the part of the 'drugged' member and a decrease in the number of communications addressed to him by the others. The other group members, each of whom was on a placebo, uniformly increased the frequency of their interactions with each other."²

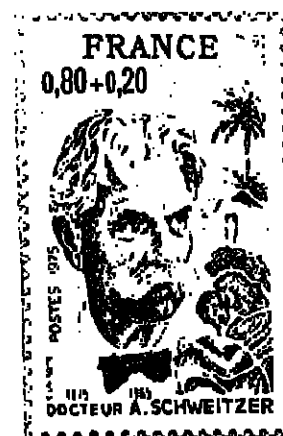
Reconciling Data

In an attempt to reconcile what was referred to on pages 86-87 with what was recorded on pages 62-63, I reviewed the original study. It was described as "a pilot study, one of a series currently being conducted to assess the effects of psychoactive agents on social interaction processes."³ However, the authors' 1971 book refers neither to later, nor more extensive nor additional studies. No subsequent report has appeared.

The "mystery" resolves as follows: It was a single report of 21 subjects; the study "consisted of groups of persons who interacted regularly in their work or leisure setting, that is, worked in the same office or met regularly for lunch. They were drawn from a non-patient population and each group consisted of three subjects between 20-45 years of age. Seven such groups were recruited from the staff of a San Francisco nonpsychiatric hospital." The investigators "requested cooperation of the group for a total of one evening a week for four successive weeks." Thus 7 groups (of 3 subjects each) times 4 weeks equals "28 discussion groups" (page 61). The subjects knew they were

Medicine on Stamps

Albert Schweitzer



This year is the centenary of the birth of the 1952 Nobel Peace Prize winner. First a musician and theologian, at the age of 30 he decided to study medicine and become a missionary physician. After receiving his M.D. from Strasbourg in 1913, he went to Lambarene, Equatorial Africa, and started his hospital in a chicken coop. This slowly grew into a medical complex that became world-famous. Stamp issued by France.

Text: Dr. Joseph Kler
Stamp: Minkus Publications, Inc., New York

participating in a psychoactive drug experiment but apparently were "blind" as to who received active drug or placebo. Not surprisingly, the authors did not report any statistically significant discrimination by subjects between placebo and active medication. It would seem psychiatrists were also "blind"—they could not discriminate between the medication and placebo—"they were more often wrong than not."

Baffling Science

The data is interesting. Fifty-five per cent of placebo subjects thought they had a tranquilizer or stimulant and 49 per cent of subjects on medication were judged to have a placebo or stimulant. The authors, on the other hand, who do not state whether their observations were under double blind conditions, claim that their analysis based on "the last 7 minutes of group interaction and 4 previously determined [sic] two-minute samples" did find a difference even though the "two-minute sampling of the interaction process does not yield very stable data."³ The latter were thus discarded and "the behavioral data presented [were] therefore...based largely on the structured situation transcript." The authors state in their 1967 paper: "The small number of groups studied so far and the methodologic limitations already discussed caution us not to generalize too freely from the findings." Yet both these data and conclusions were used for two papers and a hardbound book.

Frankly, after more than 120 published papers and thirty years participation in research, I must confess that some "science" baffles me. It is a "mystification."

1. The better term, according to the National Commission on Marijuana and Drug Abuse, is drug dependence.

2. *Mystification and Drug Misuse*, H. L. Lennard et al, Jossey-Bass, Inc., San Francisco, 1971.

3. *J. Nerv. & Ment. Dis.* 145:69, July, 1967.

Medical Tribune Reports

DR. HENDLEY

DR. COREY

'Any Conclusions Premature'

Medical Tribune Reports

DR. KNIGHT

DR. MOGANCHAN

(Continued from page 1)

Nearly 20% Not Immune

Dr. Cooper's advice was succinct: "We bring girls in for susceptibility screening and immunization during the menstrual period. And we see them without their mothers."



By JAMES MAGEE
Medical Tribune World Service

"Because of heavy frost, production

134 Tons Drawn From Stocks

The shortages of licit opium supplies are developing at a time when de-

...primes are developing at a time when the

A report by the Board for 1974 notes that intensive research is being conducted in several countries to increase yields and to find substitutes. Poppy-growing areas are also being extended. At the same time, several countries will continue to release opium from stocks.

There are doubts, however, whether

E- There are doubts, however, whether

US Biggest Codeine User

Statistics published by the Board for 1973 show that world consumption of codeine rose for the first time to 163 metric tons in that year, against an average of 154.5 tons for the three preceding years. The U.S. is now the largest consumer of codeine in absolute figures (33 tons in 1973), while Denmark and Finland are the largest per capita consumers (411 and 298 kg. per million inhabitants).

million inhabitants).

Pain: a call to action.

Whenever an APC/narcotic is indicated

Percodan[®] Tablets

INDICATIONS: For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS: Hypersensitivity to anycodeone, aspirin, phenacetin or caffeine.

WARNINGS: *Drug dependence:* Buprenex can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Physical dependence, physical dependence and tolerance may develop upon repeated administration of Percodan. It should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic containing preparations. Unlike other narcotic containing medications, Percodan is subject to the Federal Controlled Substances Act.

is subject to the Federal Controlled Substances Act. *Usage in ambulatory practice:* Cyclozine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient taking Percodan should be cautioned accordingly. *Interaction with other central nervous system depressants:* Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, or other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with Percodan may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should

Usage in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Percodan should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Usage in children: Percodan should not be administered to children.

Salicylates: should be used with caution in the presence of peptic ulcer

PRECAUTIONS: Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to dilute cerebral spinal fluid pressure may be markedly degenerated in the presence of the injury. Other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotic produces adverse reactions which may obscure the clinical course of patients with head injuries.

Special risk patients: Percodan should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

ADVERSE REACTIONS: The most frequently observed adverse reactions include light-headedness, dizziness, vertigo, nausea and vomiting. Some of these adverse reactions may be alleviated if the patient lies down.

DRUG INTERACTIONS: The CNS depressant effects of Percodan may be enhanced by alcohol, barbiturates, and other CNS depressants.

MANAGEMENT OF OVERDOSAGE: Signs and Symptoms: Serious symptoms with Percodan is characterized by respiratory depression, extreme analgesia progressing to stupor or coma, slurred speech, rigidity, cold, clammy skin, and sometimes bradycardia and hypotension. In severe overdoses, hypotension, cyanosis, cardiac arrest and death may occur.

Precautions: Primary attention should be given to the assessment of gas respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic and analgesic, although an overall anesthetic specific sedatives against respiratory depression, may result from overdosage or unusual sensitivity

apnea which may result from overdosage or unusual sensitivity, respiratory, including apnea. Therefore, an appropriate dose of one of the antagonists should be administered, preferably by the intravenous route, simultaneously with efforts at respiratory resuscitation. Since the dose of action of oxycodone may exceed that of the antagonist, the patient should be kept under continued surveillance and repeated doses of the antagonist should be administered as needed to maintain adequate respiration.

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Abstract

- ☐ rapid acting
- ☐ effective, reliable oral analgesia in moderate to moderately severe pain
- ☐ oxycodone, the principal ingredient of Percodan, is one of the more readily absorbed oral narcotic analgesics
- ☐ one tablet q 6 h*

Percodan®

Each yellow, scored tablet contains 4.50 mg. oxycodone HCl (Warning: May be habit forming), 0.38 mg. oxycodone terphenylate (Warning: May be habit forming), 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.

^aSee dosage and administration section of Brief Summary

Whenever an APC/narcotic is indicated.

EN-058

Mayo Investigator Stresses Rauwolfia Study's Limitation

Continued from page 1

475 women with cholelithiasis. Records of the women with breast cancer were then checked to determine how many had been treated for hypertension and what agents were being used.

Obviously, this differs significantly from a study that would examine rauwolfia patients and then determine the incidence of breast cancer among them.

It was found that 60 per cent of both groups of hypertensive women were untreated. This and other factors greatly reduced the number of women in the study.

Focused on 2 Small Groups

Ultimately the Mayo researchers focused on two relatively small groups. There were a total of 28 breast cancer patients—of whom 8 were on rauwolfia derivatives alone and 20 were on such drugs plus other antihypertensive agents. There were 38 women with cholelithiasis in the control group and 9 of them were on rauwolfia and 29 were on rauwolfia plus other agents.

"From our data it is not possible to see any difference between breast cancer and cholelithiasis," Dr. O'Fallon told MEDICAL TRIBUNE. "If the use of

rauwolfia causes an increased risk in breast cancer, it must also proportionately increase cholelithiasis.

"We did, however, then make a preliminary examination of 50 women who had both breast cancer and cholelithiasis—and we found only three had used rauwolfia drugs—amounting to only 6 per cent. Now from this data it is not possible for us to see any difference between breast cancer and cholelithiasis. There is no difference between these two groups.

"If the use of rauwolfia increases the risk of both breast cancer and cholelithiasis, we would expect to see a higher percentage of rauwolfia users among women who had only breast cancer or only cholelithiasis.

"Therefore we find it unlikely that both diseases have an increased risk as a consequence of exposure to rauwolfia. However, we don't think we have settled the discussion. This is too small a group for that purpose."

Dr. O'Fallon and his associates are working on a much larger prospective study that may throw new light on the relationship of breast cancer, cholelithiasis, and hypertension as well as any possible relationship with rauwolfia derivatives.

A Cervical 'Dilatometer'



"Dilatometer," being developed by Timothy J. Kriewall, Ph.D., of the University of Michigan, measures cervical dilation during labor by using a magnet attached to one side of the cervix and a sensor attached to the opposite side.

Tribune Economic Analysis



Foreign Dumping Would Be Severe Blow to Economy

The European and Asian economies competing with America are literally eating their surplus production of everything. They have already shut down their auto and appliance plants. They are only beginning to shut down the mills that produce their basic materials. But they have not yet slashed the export prices of the surplus they are stacking.

The clock is running out on how long the foreign plants ringing the industrialized world from Stockholm to Tokyo can hold the line on export price dumping. None of them will have any choice if the slump is still here by autumn.

When the American economy is clicking, the contribution it makes to world stability is to absorb the very surplus of foreign production that is now piling up. American industry can do very well without competing for markets abroad. But foreign industry will literally be out of business if the American economy does not open up in a matter of months to permit it to compete again with American industry for American customers.

In California, Japanese steel is selling for more than American steel is going begging for. This will not continue very long. Either steel-buying will come back inside America, in which case everything will come back, or Japanese steel will start looking for American customers at giveaway prices. In that tragic case, America's steel industry will follow her automobile industry into a traumatic shutdown.

Thanks to America's largesse, her competitors are well fortified with spare dollars needed to subsidize the dumping they haven't yet unleashed. If need be, they will buy the sales and the jobs needed to keep them afloat. If they are driven to "dump" their way back to work, they will sink the American economy as they do.

Now that the interest rate on T bills has dropped, do you think short-term municipal bonds are good bets? Do you call five-year municipal bonds the outer limits of short-term, or do you mean one year?

Chicago Physician

Short term municipals were the best investment value available when interest rates were up. They still are. By short term, I mean one year.

I have held onto my Pennsylvania Railroad stock because I just couldn't face the loss it entails, but now that the economy is falling on its face, maybe I should get whatever I can out of it. Would you advise me to do so?

Cleveland M.D.

You have answered your own question. Your Penn Central is worth more to you as a tax loss than as ongoing speculation.

Marriage Breakdown Said to Spur VD Rise

Medical Tribune World Service

GENEVA—Marriage breakdown, with consequent instability of sexual relationships, is becoming an important contributing factor in the increase in sexually transmitted diseases, according to a British psychiatrist.

Divorce figures have been rising steadily since 1958 in many countries, including the United States, United Kingdom, France, Germany, Japan, and the Soviet Union, and show a correlation with the statistical pattern of venereal disease, said Dr. Jacobus Dominian, of Central Middlesex Hospital, London.

Dr. Dominian, who was speaking here at a World Health Organization meeting on health education in the control of sexually transmitted diseases, said that there is as yet little direct evidence linking marital breakdown with VD because the phenomenon is of such recent origin. But the problem affects millions of human beings, he said, and is beginning to rank with other prominent social pathologies, including alcoholism, drug addiction, and delinquency.

3 Main Time Phases

He divided the pathology of marriage breakdown into three main time phases: the first five years of marriages; the period from the parents' early 30s to the departure of the children some 20 years later; and the period following the children's departure.

Dr. Dominian characterized the three phases in this way:

● In the first, and often most crucial, phase of marriage, there are two types of problem, physical and psychological. Difficulties may include nonconsummation or failures in erection and

ejaculation, and lead to unsatisfied desire or a search for reassurance.

Pregnancy is another high-risk time. If sexual activity is reduced, the man may begin extramarital relationships, which, if they lead to VD, put both mother and child in danger.

In the postpartum period, a small but significant proportion of women develop forms of moderate depression, irritation, tension, and loss of sexual desire. This also may induce the partner to seek sexual satisfaction elsewhere.

The two main psychological difficulties are psychopathy and the identity crisis. The psychopathic partner shows little affection but is often sexually demanding and easily becomes promiscuous. A person suffering from an identity crisis in youth may discover that the marriage partner is irrelevant to the self as it develops years later.

● In the 30-50-year age phase, one of the common patterns is a change in personality, often by the wife. She starts her marriage in a state of emotional dependence and compliance, but, as she grows older, begins to question her husband's dominance. If this leads to conflict, she may withdraw sexually and seek extramarital partners as a sign of defiance. The husband may then retaliate by also seeking other partners.

● The third phase, from 50 until death, is a phenomenon of this century, when two or more decades have been added to the life span. Previously, widowhood commonly preceded possible divorce.

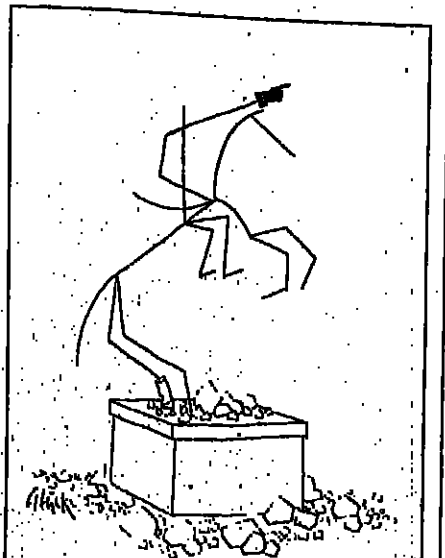
The principal sexual problem at this stage is male impotence that is age-related and likely to become increasingly serious. If it persists continuously

for more than two or three years, the prognosis is poor. So the search for aphrodisiacs begins, and both partners also consider taking other lovers to provide reassurance.

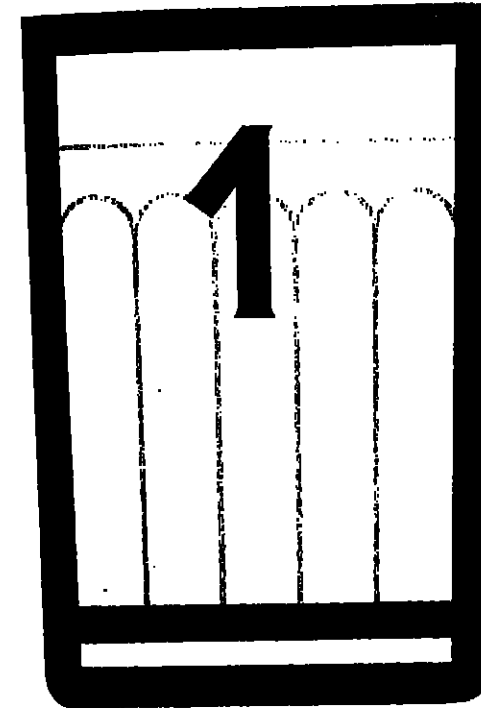
"A great deal of counseling is needed to help such a couple. The wife has to understand that no other woman is displacing her, and the husband has to learn to accept his disability and compensate with extra affection for the wife."

Another of the phenomena of this age group is the reaction by either the husband or wife to the realization that the end of life is approaching.

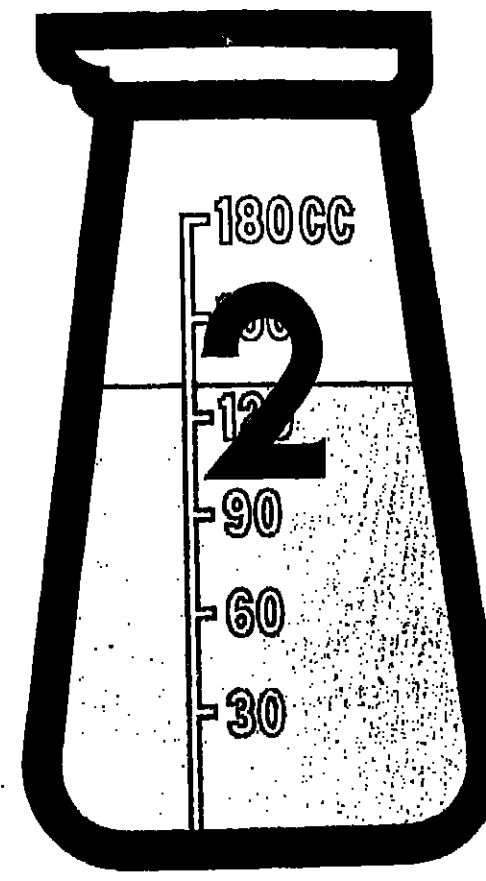
"After having lived meticulous and conventional lives, they will suddenly experience the desire for a late sexual fling and try to recapture the emotional excitement of adolescence."



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4 tablets (0.5 Gm each) STAT—then
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Basic therapy with
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● Effective against susceptible *E. coli*, *Klebsiella*, *Aerobacter*, *Staph. aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms.

Note: Carefully coordinate in vitro sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzazole acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical

signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma, in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); allergic reactions (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitivity reactions (nausea, emesis, myocarditis); gastrointestinal reactions (nausea, vomiting, abdominal pain, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); CNS reactions (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); miscellaneous reactions (drug fever, chills, toxic nephrosis with oliguria and anuria, periarthritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

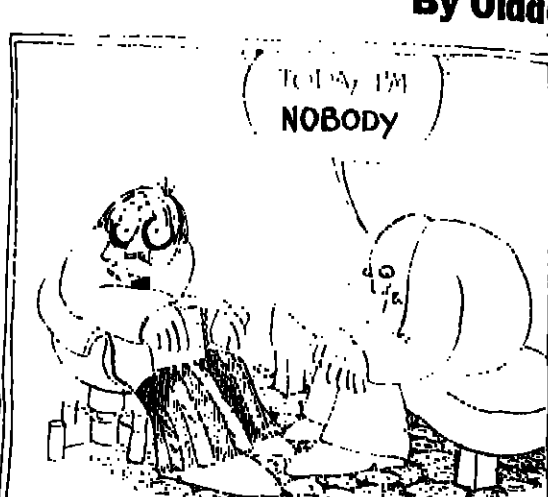
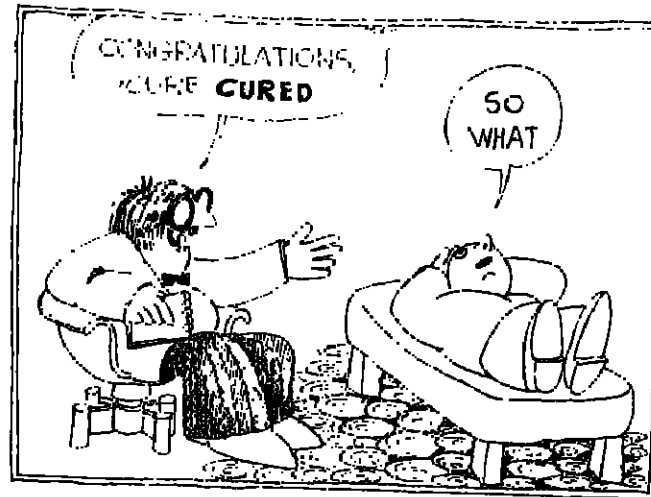
Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm b.i.d. or t.i.d. depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/kg/24 hrs. Maximum dose should not exceed 7.5 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Clinical Trials



By Olden

CAR CLINIC

Is Leasing a Better Way to Go?

By Dr. JOHN McDERMOTT
Medical Tribune Consultant

The courts will soon decide if banks may operate a new service, auto-leasing, which many physicians have turned to for their transportation needs.

IRS guidelines for automobile deductions exclude cars used for pleasure or driving to work. However, the average physician's business car is one that does fulfill the criteria for a tax deduction. The IRS itself feels that there might be a tax advantage for persons who lease a car and then use it more than 50 per cent of the time for business. In other words, roughly 50 per cent use of an automobile for professional reasons might make leasing worth considering.

In contrast to desirability of leasing is the fact that certain automobiles, as well as certain drivers, may not make leasing advantageous, regardless of the amount of business use the vehicle gets. Cars that by nature of demand maintain high resale values tend to have less tax benefit to their owners when obtained on a lease basis. Similarly, owners who take excellent care of their automobile and at time of trade-in have "cream puffs" also will not find leasing particularly to their advantage. Most leasing arrangements are based on deterioration of the car to a greater degree than these drivers will tolerate.

Open vs. Closed-End Contracts

Basically, there are two types of leases. With the open-end contract, a person leases a car for an established period of time and pays for the car's expected depreciation on a monthly basis. With this type of lease the owner must be able to guarantee that the car will be worth the difference between its original value and its value at the end of the lease. In recent years, this type of lease has been fraught with difficulties, particularly if the automobile was a large gas-guzzler because the market for this type of car has become very bad. The lessee can end up paying for changes in market mood as well as the depreciation of the automobile itself.

The second type of lease, the closed-end lease, is different in that the leasing company agrees to take the car back at the end of the lease and there is no worry concerning its value. These leases, however, are usually more expensive than the open-end type, and

the consumer is the one who always must take the gamble.

Where to Lease?

As mentioned above, banks are now into the leasing business and have joined the ranks of the automobile dealers, the automobile corporations themselves, and, of course, the auto-leasing companies. No hard, fast rule can be made as to the best place to obtain a lease. However, the Better Business Bureau and local consumer protection agencies may well be able to tell you where not to lease. In general, companies involved in the sale of the vehicle itself tend to have as much interest in unloading the particular vehicle as in the financial arrangements. Thus, with interest being divided, this can be a financial advantage to the customer. However, leasing through an independent company does offer some leverage if, for example, there is difficulty with the vehicle itself.

Repair Problems

Auto-leasing was long thought to be the panacea for the motorist faced with troublesome repairs. In early leasing arrangements it was common to guarantee the vehicle in an established condition of operation. Thus, when repairs were necessary, the lessor merely dropped off the sick car for a well one.

Unfortunately, this type of automobile "HMO" is no longer commonly available. Today most leased automobiles are repaired in the same fashion

Strong Interest Evidenced in Psychobiology

Medical Tribune Report

Boston—Heightened interest of clinical psychiatrists in the genetic and physiological origins of mental disorders was evidenced when an overflow audience of 600, many of them clinicians, attended a day-long symposium on the biological substrates of mental illness at McLean Hospital here.

The occasion was the announcement by the hospital of plans to construct a psychobiological research center.

The audience was so large that the meeting had to be transferred to the hospital's gymnasium, with some persons able to hear the speakers only over closed-circuit television in an adjoining room.

The biological field held sway 60

The planned research center will combine efforts now underway separately at Harvard, the Massachusetts Institute of Technology, Massachusetts General Hospital, and McLean, under the direction of Dr. Seymour Kety, who is Professor of Psychiatry at Harvard.

The Pendulum Swings

In discussing what he called a "really remarkable increase in interest" in the biological bases for mental disturbances, Dr. Kety told MEDICAL TRIBUNE after the meeting that "in a field where we don't know the answers, the pendulum of attention always swings back and forth" while the main body of work moves forward.

"The biological field held sway 60

Crafty Solution to Dialysis Boredom



An "activities therapy" program has been started for patients undergoing kidney dialysis at Long Island Jewish-Hillside Medical Center, New Hyde Park, N.Y. Finding that boredom was common during the three-to-five-hour stretch needed for dialysis, volunteers have been teaching some of the patients crafts that can be performed with one arm and playing games with others.

as any other owned automobile, but some, however, must, in addition to being repaired at the owner's expense, be repaired in the lessor's garage. The implications of this, of course, need not be elaborated.

Auto repairs are enough of a problem without one being saddled to having repairs made in any one particular garage. For this reason, and the problems alluded to above, it is very wise to shop for an auto lease, and either have the contract examined by a professional or take the time to read the small print yourself.

House Staffers Eye Exit In Insurance Cost Crisis

Medical Tribune Staff

New York—A questionnaire survey of house staff officers in New York City has shown that 32 per cent are planning to leave New York State at the end of their training due to high malpractice insurance costs.

Another 40 per cent told the Committee of Interns and Residents that they would "probably" leave. Only 10 per cent of the 878 house staff respondents said they would be able to stay if insurance rates increase.

or 70 years ago," he said, "and then 25 years ago the pendulum swung toward analysis. Ten years ago it went toward community psychiatry and an overriding interest in society and its ills."

At that time, he recalled, a similar meeting at McLean drew only 200 persons; almost all of them in research. "The reasonable, sensible psychiatrist always thought, however, that mental illness was an interaction between biology and life experiences."

Interest in the biological side began again to increase several years ago, Dr. Kety recalled, as researchers began to come up with a data base instead of dogma and some "handles" on the problem of mental illness.

3-Drug Combination Reduces MS Relapse Rate Significantly

By ALAN FITZGIBBON
Special Tribune Correspondent

BETHESDA, Md.—Fourteen multiple sclerosis patients experienced a significant reduction in relapse rate when treated with combined azathioprine, antilymphocyte globulin (ALG), and prednisone to achieve intensive immunosuppression, a British investigation has found.

Most of the patients had the intermittently active type of the disease, Dr. Eugene M. Lance, who now practices in Honolulu, told an MS symposium held by the National Institute of Neurological Diseases and Stroke.

"Using patients as their own controls, there was found to be a significant reduction in the relapse rate compared with the number predicted on the basis of their experience before treatment," he said.

"Many patients underwent relapses a few weeks or months after significant drug reduction, and for this reason some required continued immunosuppressive treatment, though all drugs have been withdrawn in most cases."

The 14 patients, 12 of whom had active multiple sclerosis when the experiment started and 10 of whom had had the disease for three years or less, were given 3 mg./Kg. of azathioprine daily throughout the first year of the trial. They received 500 mg. of ALG intravenously on the seventh day of the experiment and on weekdays of the following three weeks. Prednisone was begun at a dose of 200 mg. a day and tapered rapidly to 20 mg. a day by the seventh day.

All patients received an intravenous infusion of aggregate-free normal horse IgG on days 1 and 4 in doses of 60 and 30 mg./Kg., respectively.

Reactions Linked to Prednisone

After their discharge from the hospital the patients were maintained on 20 mg. of prednisone and 3 mg./Kg. of azathioprine daily, but at the end of the year those doses were cut down in preparation for complete withdrawal.

A few of the patients developed adverse drug reactions, mostly minor and related to the prednisone. One patient developed signs of serum sickness, which required cessation of the ALG treatment, and another developed mild anaphylactic symptoms, requiring reduction in ALG dosage.

Three raters who evaluated the patients' progress using a four-point scale of sensory and motor modalities, balance, speech, and vision, agreed that during the first two or three weeks of treatment every patient improved, especially during the first few days of ALG therapy.

"The degree and nature of improvement varied greatly, and in a few cases symptoms of many years' standing improved," Dr. Lance said.

His co-workers at the Clinical Research Centre, Harrow, were Drs. J. Abbes, M. Kremer, V. Jones, and S. Knight, and Sir Peter Medawar.

MSS, HL-A Genes Linked

Dr. Milton Alter reported that an analysis of HL-A tissue types in nine

families each having at least two persons with multiple sclerosis indicated that a hypothesized gene responsible for susceptibility to the disease, which he termed the MSS gene, may be closely linked to the HL-A genes and may be associated with or the same as the immune response gene.

"Our genetic analysis implicated a dominant gene in determining multiple sclerosis susceptibility or a defective gene determining multiple sclerosis resistance," said Dr. Alter, who is chief of the neurology service at the Minneapolis Veterans Hospital.

Contradictory Studies Noted

"The results were clear-cut and therefore hard to reconcile with other genetic analyses of multiple sclerosis in which evidence of simple Mendelian inheritance was lacking. It is likely that the genetic susceptibility to multiple sclerosis, or lack of resistance, requires an environmental trigger, and not all genetically susceptible individuals develop clinically manifest multiple sclerosis."

"Alternatively, there might be a modified gene which operates to suppress the effect of the postulated MSS gene. Lack of an environmental trigger or the modifying gene may explain the exception that we noted among the sibs in the 'G' family, where one individual with the appropriate haplotype was nonetheless normal, as well as the observation that most cases of multiple sclerosis are sporadic rather than familial."

The exception that Dr. Alter noted was an apparently unaffected woman in her early 30s who had inherited the same haplotype as her affected siblings. "She is still in the age at risk," he commented, "and may therefore inherit multiple sclerosis to make this what appears to be a virtually perfect segregation" of HL-A types.

Dr. Alter's co-workers were Mary Harsh, of Dr. Alter's service, and Dr. Edmond J. Yunis, of the University of Minnesota.

Transfer Factor Tested

Dr. Torben Fog reported that a pilot test of transfer factor is being carried out in his Kommunehospital in Copenhagen to determine whether a larger double-blind trial with the hard-to-get substance is warranted.

"If there is demonstrable progress [of MS] during the one to two years of treatment, we may conclude that there is reasonable doubt about continuing this study," he said. "If not, the need of enough substance for a double-blind trial is imperative."

Ten multiple sclerosis patients were entered in the test between February and June last year. No side effects have so far been found but the treatment appears to reverse the patients' migratory inhibition factor reaction test results only temporarily. No definite conclusions about the progress of their disease could as yet be drawn.

Bullet in Heart Removed by 'Basket' Catheter



A .22-caliber bullet was removed from a man's heart and drawn out through a vein in his arm by means of a catheter with a collapsible fine-wire "basket" at Harper Hospital in the Detroit Medical Center. In this photo, the bullet has been snared by the catheter and is being lifted up inside the heart.

IMMATERIA MEDICA

May 6, 1856: Happy Birthday

We don't know if your local psychoanalytic society came up with a birthday cake but May 6 was the birthday of Sigmund Freud, M.D., the first physician to write a good book about himself but not the first to be funny. He got around to writing *Jokes and Their Relation to the Unconscious* (1905) because his friend Dr. Wilhelm Fliess, on reading proofs of *The Interpretation of Dreams*, complained that the dreams were too full of jokes. That led Freud to start studying jokes; he just couldn't let a free association slip by.

Jokes and Their Relation to the Unconscious has disappointed more comedians than Hollywood because it is no secret fountain of joyous boffos topping joyful boffos. It is a somberly technical study of jokes, wit and humor and their purposes, most of which are unconscious. But for our birthday jubilee, we dug it out and offer some samples. One was what Freud called "an American anecdote." It seems that two unscrupulous businessmen had amassed large fortunes and wanted to get into "good society" by having their portraits painted by a celebrated artist. Then they threw a large dinner party, inviting all the best people including a great critic and influential connoisseur. They themselves led the critic up "to the wall upon which the portraits were hanging side by side, to extract his admiring judgment on them."

"But where's the Saviour?" asked the critic. As Dr. Freud pointed out, the critic thus said what he didn't dare say openly through an allusion to Christ on the cross between two thieves.

The Baroness' Cries

We'll pass over why Freud called this an American joke to go on with another in which a Baron summoned a leading physician to deliver his wife. The physician, after looking in on the Baroness, suggested that he and the Baron play cards—much to the Baron's astonishment. They played—until a cry of pain from the Baroness—"Ah, mon Dieu, que je souffre!"—caused the

Baron to jump out of his chair. The physician waved him down: "It's nothing. Let's go on with the game." A little later the pregnant woman cried: "Mein Gott, mein Gott! What terrible pains!"

As Dr. Freud tells it, at that point, the anxious Baron asked: "Aren't you going in, Professor?" The physician: "No, no. It's not time yet."

"At last there came from next door an unmistakable cry of 'Aa-ee, aa-ee, aa-ee!' The doctor threw down his cards and exclaimed: 'Now it's time.'"

That joke, said Dr. Freud, showed how the cries of pain of an aristocratic lady in childbirth changed their character little by little, with pain causing primitive nature to break through all layers of education. It also showed "how an important decision can be properly made to depend on an apparently trivial phenomenon."

So you now know what kept Dr. Freud off the vaudeville circuits, the TV networks of our childhood. What has always bothered us is how a physician so quick to detect sexual puns picked a name like psychoanalysis for his newly-invented specialty; after all, psychoexamination was available.

But anyhow, *Happy Birthday, Dear Sigmund!* You've kept the comedians, the cartoonists, the novelists, the playwrights—and now the psychobiographers, not to mention a growing number of medical specialists—going in this grim 20th Century-Fox world, despite two World Wars, the Korean and Vietnam Wars, depression, starvation, Watergate, pollution, moonshots, television, and sex therapy.

Unlike Dr. Fliess, we don't think there were enough jokes in *The Interpretation of Dreams*. We had hoped it would be a real boffo, the Disneyland of Medicine with Sophia Loren playing Botticelli's Venus on the Half-shell. She comes in and you say, "Lie down on the couch, young lady, I'm the doctor here..." And she says, "Don't get funny with me," and you wake up laughing.

Instead Dr. Freud says you love your mother. Or father. Some joke, Dr. Fliess.